

# The Medical Times and Register.

VOL XXXVII NO. 4, 1890

PHILADELPHIA AND BOSTON, JUNE, 1890.

WHOLE NO. 962.

FRANK S. PARSONS, M. D., - Editor.  
DORCHESTER, BOSTON, MASS.

JOSEPH R. CLAUSEN, A. M., M. D., Manager.  
NO. 717 BETZ BUILDING, PHILADELPHIA, PA.

## .....EDITORIAL STAFF.....

T. H. MANLEY, M. D., New York, N. Y.

LOUIS LEWIS, M. R. C. S., (Eng.) Philadelphia, Pa.

S. H. MONELL, M. D., Brooklyn, N. Y.

J. A. TENNEY, M. D., Boston, Mass.

J. J. MORRISSEY, A. M., M. D., New York, N. Y.

E. B. SANGREE, A. M., M. D., Nashville, Tenn.

LOUIS FISCHER, M. D., New York, N. Y.

EDWARD A. TRACY, M. D., Boston, Mass.

H. B. SHEFFIELD, M. D., New York, N. Y.



## ORIGINAL

### CHILDREN WITH ABNORMALITIES, BASED UPON THE REPORTS OF TEACHERS.

BY ARTHUR MacDONALD.

Specialist in the United States Bureau of Education, Washington, D. C.

The word abnormality is not used in any rigid sense, and refers here to children reported by the teachers as peculiar or defective. It is evident that had specialists examined the children for defects, the percentages would have been higher, but our purpose is to give only those defects or peculiarities observed by the teachers.

Table I gives in general abnormalities or defects in relation to sex, mental ability, nationality, sociologic condition, and race in Washington children.

#### SICKLINESS.

Running down the column for the sickly, we note that dull colored girls show the highest per cent. (12.78) of sickliness.

Average boys of American and foreign parents, and boys of non-laboring classes, show more than 7 per cent. of sickliness.

The two lowest per cents. of sickliness are with the boys and girls of foreign parentage (2.13 and 2.60.) Low per cents.—that is, lower than 4 per cent—are shown in the case of bright boys, girls of American and foreign parents, and boys of laboring classes. The boys of nonlaboring classes almost double (7.37) in per cent. of sickliness (3.72) the boys of the laboring classes.

#### NERVOUSNESS.

Taking the column of figures under "nervous," Table I, the high per cents., or those above one and twenty-hundredths per cent., say, are shown by the dull boys (1.24), average boys (1.42), boys of American parents (1.28), boys of American and foreign parents (1.79), and boys of nonlaboring classes (2.03). The lowest per cents., say fifty-hundredths or less, are shown by the dull girls (0.33), girls

and boys of foreign parents (0.19, 0.19), girls of American and foreign parents (0.29), bright and dull colored girls (0.23, 0.45), the average colored boys (0.26). The data are meager as to abnormalities in colored children, but their low per cent. of nervousness is noticeable.

#### DEFECTS IN EYESIGHT, HEARING AND SPEECH.

Eyesight.—The highest per cents. of eye defects, say above 1.50 (Table I), occur in average boys (1.63), girls of American parents (1.52), boys of American and foreign parents (1.57), girls of nonlaboring classes (1.73) and boys of nonlaboring classes (1.97).

Some of the lowest per cents., say 0.70 and less, are shown by girls and boys of foreign parents (0.38, 0.58), girls of American and foreign parents (0.59), and by all colored children reported.

Hearing.—High per cents. of defective hearing, say about 1 per cent., occur in dull boys and boys of American and foreign parents. It may be that the apparent dullness of some children is due to defective hearing rather than mental defect.

The lowest per cents. occur in bright girls (0.15), bright boys (0.45), girls and boys of foreign parents, girls of nonlaboring classes, and bright colored girls.

Speech.—A low per cent. of defective speech occurs in all girls (0.28), while in all boys it is 1.11.

#### CONVULSIONS.

Convulsions are comparatively frequent in dull boys (0.16) and boys of nonlaboring classes (0.13), and very rare in girls (0.01).

#### LAZINESS.

While most all children, boys especially, are lazy at times, there are nevertheless a number of children who seem to be chronically lazy. The highest per cent of laziness is shown by the dull boys (2.97). Comparing all boys and girls (0.22), the boys are much more lazy (1.33).

While of course there is no standard

for laziness, yet there are certain children whose excessive laziness is apparent to every teacher. The same is true in regard to unruly children.

#### UNRULY CHILDREN.

As we might expect, the boys (5.47) are very much more unruly than the girls (0.25). The highest per cent. of unruliness in colored children (4.75).

Comparing the laboring and non-laboring classes, the girls of the non-laboring class are less unruly, while the reverse is true in the case of the boys.

Comparing children of American and foreign parentage, the girls of American parentage are less unruly than those of foreign parentage. The difference in the case of the boys is small.

#### ABNORMALITIES IN RELATION TO AGE.

In Tables II and III are given the per cents. of different abnormalities according to the nearest age.

Taking the time of second dentition or shedding of the teeth, which begins about the age of 6 or 7, and also the time of puberty, which occurs at about 12 years in girls and 14 years in boys, it will be interesting to see what relation these critical times in child development bear to the abnormalities as reported by the teachers.

In Tables II and III, which give percentages for age of boys and girls, it will be seen that there is, in general, an increase of abnormalities at dentition time and at the age of puberty.

If we examine Table II for boys, we see that sickness increases as we approach puberty; nervousness is high at dentition time and just before and at puberty; laziness is large at puberty (2.17), as is unruliness (8.16.) Table III, which gives the percentages for girls, shows a somewhat similar condition.

\*For further study of children, the reader is referred to a work entitled "Experimental Study of Children" (by the writer), to be published by the United States Bureau of Education, Washington, D. C.

TABLE I.—*Abnormalities or defects in relation to sex, mental ability, nationality, sociologic condition, and race, as reported by the teachers.*

Divisions according to sex, mental ability, nationality, sociologic condition and race.	Total No.	Sickly.		Nervous.		Defective in—			Convulsions.	Lazy.	Unruly.
		Total.	Percent.	Total.	Percent.	Eyesight.	Hearing.	Speech.			
Bright girls.....	3,206	133	4.04	19	.58	41	1.33	5	.15	.15	.03
Bright boys.....	2,899	111	3.88	32	1.10	31	1.07	13	.45	.16	.04
Dull girls.....	917	57	6.23	3	.33	7	.76	6	.65	.2	.52
Dull boys.....	1,214	64	5.27	15	1.24	16	1.32	13	.07	14	1.15
Average girls.....	4,304	217	5.04	35	.81	57	1.39	20	.47	.17	.4
Average boys.....	3,873	241	7.15	48	1.42	55	1.63	27	.8	.58	1.72
Girls, American parents.....	6,463	244	5.32	52	.8	98	1.52	26	.4	.22	.34
Boys, American parents.....	6,024	330	5.48	77	1.28	82	1.36	41	.68	.67	1.11
Girls, foreign parents.....	1,038	27	2.60	2	.19	4	.38	3	.29	..	..
Boys, foreign parents.....	1,036	22	2.13	2	.19	6	.58	2	.19	.9	.87
Girls, Amer. and for. parents.....	1,019	36	3.58	3	.29	6	.59	2	.2	.2	..
Boys, Amer. and for. parents.....	868	64	7.17	16	1.79	14	1.46	10	.12	.12	1.34
Girls, laboring classes.....	3,151	204	6.47	27	.86	46	1.46	18	.57	.18	.57
Boys, laboring classes.....	2,739	102	3.72	14	.51	21	.77	12	.44	.21	.77
Girls, non-laboring classes.....	3,013	140	4.66	25	.88	52	1.73	8	.27	.4	.14
Boys, non-laboring classes.....	3,093	228	7.37	68	2.08	61	1.97	29	.94	.46	1.49
All girls.....	8,520	407	4.78	57	.67	18	1.27	31	.36	.24	.28
All boys.....	7,953	416	5.23	95	1.2	102	1.28	53	.67	.88	1.11
Bright colored boys.....	..	..	..	..	..	..	..	..	..	..	..
Bright colored girls.....	1,751	116	6.63	4	.33	4	.23	2	.11	.3	.17
Dull colored boys.....	..	..	..	..	..	..	..	..	..	..	..
Dull colored girls.....	673	86	12.78	3	.45	4	.59	6	.89	5	.74
Average colored boys.....	1,156	76	6.57	3	.26	5	.43	4	.25	8	.69
									1	.09	..
									..	..	28 2.42

TABLE II.—*Per cent. of different abnormalities according to age, computed on the total number of boys for each age.*

Nearest age.	Total No.	Sickly.		Nervous.		Defective in—			Convulsions.	Lazy.	Unruly.
		Total.	Percent.	Total.	Percent.	Eyesight.	Hearing.	Speech.			
6.....	147	7	4.76	8	2.04	..	..	..	4	2.72	..
7.....	533	28	5.25	3	.56	5	.94	2	.38	10	1.84
8.....	787	28	3.56	11	1.40	4	.51	5	.64	12	1.52
9.....	878	41	4.67	9	1.03	13	1.48	5	.57	8	.91
10.....	930	44	4.73	14	1.51	15	1.61	3	.32	13	1.4
11.....	862	57	6.61	12	1.39	10	1.16	3	.35	9	1.04
12.....	986	61	6.19	16	1.62	17	1.72	8	.81	9	.91
13.....	926	54	5.82	10	1.08	13	1.4	11	1.19	10	1.08
14.....	784	48	6.12	9	1.15	7	.89	10	1.28	6	.77
15.....	528	31	5.87	5	.95	7	1.33	3	.57	2	.38
16 and over.....	592	17	2.87	3	.51	11	1.86	3	.51	5	.84
All ages.....	7,953	416	5.23	95	1.19	102	1.28	53	.67	.88	1.11
									5	.06	106 1.33
									..	..	435 5.47

TABLE III.—*Per cent. of different abnormalities according to age, computed on the total number of girls for each age.*

Nearest age.	Total No.	Sickly.		Nervous.		Defective in—			Convulsions.	Lazy.	Unruly.
		Total.	Percent.	Total.	Percent.	Eyesight.	Hearing.	Speech.			
6.....	131	..	..	1	.76	..	..	..	..	..	..
7.....	508	14	2.76	7	1.38	3	.59	2	.39	5	.98
8.....	754	27	3.58	10	1.33	6	.8	1	.13	2	.26
9.....	888	33	3.74	2	.23	15	1.7	2	.23	2	.23
10.....	939	51	5.43	5	.53	16	1.7	7	.75	3	.32
11.....	131	49	5.26	6	.64	15	1.61	2	.21	5	.54
12.....	876	59	6.74	6	.68	16	1.83	8	.91	1	.11
13.....	966	67	6.94	7	.72	18	1.86	4	.41	4	.41
14.....	833	35	4.2	4	.43	11	1.32	..	..	1	.12
15.....	656	18	5.04	4	.61	3	.46	1	.15	5	.6
16 and over.....	1,044	39	3.74	5	.48	5	.48	5	.48	..	1
All ages.....	8,520	407	4.78	57	.67	108	1.27	31	.36	.24	.28
									1	.01	19 .22
									..	..	21 .25

## MY EXPERIENCE WITH SOMATOSE IN PEDIATRIC PRACTICE

BY J. L. LANDAU, KRAKAU, AUSTRIA.

Notwithstanding the comparatively short time that somatose has been before the medical profession, the literature on this product is considerable. It is my intention in this article to give a brief review of what has been accomplished by others with this preparation in diseases of children, and also communicate the results of my own observations.

Somatose is a yellowish, odorless and tasteless powder prepared from meat, containing the albuminous elements in a readily soluble state in the form of albumoses, 84 to 86 per cent., and only traces of peptone. It is readily dissolved in water, the solution being of a brownish-yellow color. The manner of preparing this solution is deserving of special consideration. Into a wine glass containing a tablespoonful of water the desired quantity of somatose is poured, and the resulting paste stirred for a few minutes until a complete solution is obtained. The children prefer to take the preparation in water in which it is completely soluble.

The dose in which I administered somatose varied from 4 to 10 gm. (60 to 150 grains), and I am convinced that when administered in these amounts, it acts more efficiently than in larger quantities, since it is more completely utilized.

Reichmann recommends for children during the first two days 1 gm. pro die, after 8 days 3 gm. daily, and found that when given in this way no diarrhea occurred. Weber employed it in gastro-intestinal catarrh of infants with good results in doses of 1.5 to 2 gm., added to a nursing bottle full of milk. Pelzer advises that somatose be administered in milk, the so-called somatose-mothermilk. This corresponds with Rieth's albumoses milk, except that in place of the albumoses derived from egg those of meat are substituted. Especially good results were obtained by him in children

above three years of age suffering from gastro-enteritis. Pelzer gave somatose in the pure state, in a 10 per cent. sterilized solution, in water, or in the form of somatose-mothermilk. Woodbury prefers somatose milk to Rieth's albumoses milk, for the reason that after injections of the latter, the stools have the disagreeable odor of sulphur. Cronin considers somatose a valuable nutrient in acute and chronic intestinal diseases of children, since it is absorbed in the upper parts of the intestine, and does not act upon the lower part. Wolf reports his experience with this remedy in 50 cases in Monti's Policlinic, of Vienna, employing it either in the form of somatose milk, or simply dissolved in water. To children up to one year of age 4 gm. were given daily, to older children up to 8 gm. Thirty-five cases were treated exclusively with somatose, of which 15 were affected with dyspepsia, 15 with marasmus and chronic dyspepsia, and 5 with digestive disturbances. In all cases an increase of the bodily weight occurred, and the stools became normal. Cow's milk was more readily digested, and the dyspepsia was favorably influenced. Schramm employed somatose in infants backward in their development owing to inadequate nourishment, in artificially nourished children with acute dyspepsia, in cases of gastro-enteritis, in severe acute febrile intestinal diseases, and during the period of convalescence. In infants he prescribed a mixture of cow's milk with somatose solution, in equal parts, 1 liter of the mixture containing 2 gm. of somatose; older children received 2 to 3 gm. daily. Fournier used it as the sole food in acute gastro-intestinal catarrh of infants, and obtained excellent results, especially in a case of vomiting and diarrhea in an infant, 4 months old, who vomited after milk. At first dose of 1 gm. pro die were administered, and later this was in-

creased to 3 gm. The condition improved from day to day, although somatose was only administered for four days. Kraus gave it in 24 cases; 3 to 5 gm. to children up to a year old; 8 to 10 gm. to older children. He considers it an important food preparation in pediatric practice. Bartley employed somatose in two cases of cholera infantum with marked collapse, and in a case of gastro-intestinal catarrh where all nourishment was vomited. Drews reports his results with the remedy during a period of three years, giving it to healthy infants as an addition to cow's milk, since it causes fine flocculant coagulation of the milk. He also made use of it in diseases of the digestive apparatus, in acute diseases, and during convalescence from exhaustive maladies. In his opinion, it is an excellent dietetic and tonic remedy exerting a favorable influence upon the osseous development of the infant and preventing rickets.

My own experience relates to 37 cases, varying in age from 1 month to 9 years. Of these 20 children were below two years of age, 12 below six years, and 5 below 9 years. The somatose was administered in connection with the customary food. Four of the patients died during the treatment, one of acute nephritis, one of leukaemia, and two of intercurrent pulmonary inflammation.

Finally, I would report in detail the cases of special interest, commencing with a group of four cases of typhoid fever.

Case 1. K. S., 6 years old; typhoid fever and catarrhal pneumonia; anaemia, emaciated, complete loss of appetite, and stools of the appearance of pea-soup, several times daily. Somatose administered at the commencement of the disease; at first a knife-pointful, three times daily and later four times daily. After subsidence of the fever patient was weighed, and found to have gained 3 1-10 kilos.

Case 2. H. C., 7 years old; typhoid fever and bronchitis; tongue dry and

coated; stools fluid, anorexia, reseola. Somatose a knife-pointful three times daily. Notwithstanding that the temperature rose to 39 7-10 degrees, the remedy was well tolerated.

Case 3. L. G., 9 years old; typhoid fever. Toward the end of the disease the stools were still diarrhoeal. Somatose was ordered in quantity of 3 to 5 gm. daily; after two days the stools had become firm and consistent, and the appetite had improved.

Case 4. M. D., 8 years old; typhoid fever and bronchitis. During the febrile period somatose was administered. Three days after commencing its use, the stools became firmer and consistent. Patient is still under treatment.

The second group of cases comprises infants and artificially nourished children up to the age of two years who suffered from gastro-intestinal and from intestinal catarrhs. To this group belong 23 cases. Of these 10 were affected with rickets, and could not be subjected to the ordinary treatment with hypophosphites and cod liver oil on account of the presence of diarrhea. In this connection I would say that the rhachitic process was not influenced by somatose, and that up to now the best results have been obtained with phosphorus. Especially noteworthy are the following five cases comprised in this group:

Case 1. S. K., 5 months old; chronic enteritis; catarrhal pneumonia; ill-nourished and almost wasted to a skeleton; child is unable to nurse properly. Somatose, a knife-pointful, was administered three times daily, altogether 75 gm. being used. After the pulmonary symptoms disappeared, the child gained daily 30 gm., although previously to the sickness there had been no gain in weight, but rather a decrease.

Case 2. E. H., 9 months old; acute gastro-enteritis; since several days vomiting and diarrhea; stools black and green. Somatose was administered twice daily, and was well tolerated.

Case 3. G. W., 2 years old; chronic

enteritis, facial eczema, emaciation, marked rickets, dullness over the apex of the left lung; 8 to 10 stools daily. Somatose was administered, 4 to 6 gm. daily, and under its use there was a constant increase of the bodily weight from February 22, 1898, to May 7th of over 3 kilos.

Case 4. F. C., 16 months old; acute enteritis; furunculosis, bronchitis; had been nourished at the breast up to the fifteenth month and had been sick for 6 months, the symptoms being loss of appetite, frequent diarrhea, emaciation and rickets. Somatose 2 to 4 gm. daily was administered, and under its use the stools became regular and were of firmer consistency. A gain in weight of 4 1-2 kilos occurred during the six months, together with improvement in the general condition.

Case 5. S. C., 13 months old; chronic enteritis; since several months green and mucous stools daily. After somatose was given in amounts of 4 gm. daily, the stools became regular and the child improved greatly.

Finally I would call attention to a number of cases which are especially noteworthy, and relate to children ranging in age from two to nine years:

Case 1. U. D., 2 years old; chronic enteritis; pneumonia; rickets; eczema of the head. Child emaciated almost to a skeleton, and resembles in appearance a three months' old infant. After the subsidence of the pneumonia, treatment with somatose was commenced; at first a knifepointful three times daily, then four times daily; after 14 days increase of bodily weight 695 gm.

Case 2. R. G., 3 years old; acute en-

teritis, catarrhal pneumonia, rickets, and eczema of the head. Since two weeks loss of appetite, vomiting, diarrhea; 7 to 8 fluid greenish stools daily. On the second day of treatment somatose was administered, at first 1.5 gm. daily which was gradually increased to 8 gm. As early as on the second day the stools decreased in number, and on the eighth day had become completely normal; the appetite had improved, and the swelling of the abdomen had subsided entirely. During 28 days there was an increase of the bodily weight of 1800 gm.

Case 3. H. J., 4 years old; pleuro-pneumonia complicated with diarrhea. The child was treated exclusively with somatose in amounts of 4 to 6 gm. daily; during two months there was an increase in weight of 2300 gm.

Case 4. E. G., 9 years old; anæmia, scrophulosis. Under administration of somatose, 6 to 10 gm. daily, an increase in weight of 2 kilos was obtained in the course of 26 days.

On the ground of my observations I would conclude as follows:

1. Somatose can be considered as a nutrient par excellence, as it contains so much nutritive material in so small quantities, and is serviceable in diseases with a considerable waste of tissues.

2. In none of the cases was diarrhea observed during the administration of somatose.

3. Being odorless and tasteless, it is willingly taken by children in any form.

4. It exerts no influence upon the rhachitic process itself.





## SOCIETY REPORTS

### NEW YORK ACADEMY OF MEDICINE. SECTION IN ORTHOPÆDIC SURGERY.

MEETING OF FEBRUARY 17, 1899.

#### HYPERTROPHY OF THE TIBIA.

Dr. S. Ketch presented a girl, 4 years of age, whose right tibia was greatly lengthened and thickened with decided anterior bowing. He had first seen the patient in December, 1898. The epiphyses were thickened but the enlargement was not confined to them. It was most marked at the middle of the shaft but included the whole bone, as was seen by the X-rays. Length: right leg, 19 1-2; left leg, 18 5-8; right tibia, 9 1-4; left tibia, 8 3-4. Circumference: right thigh, 9 1-2; left thigh, 10 1-4; right calf, 8 5-8; left calf, 7 7-8. The disease had begun 18 months ago with a small lump on the leg and pain at night and when she walked. This was Dr. Ketch's second patient of the kind. The first one was a girl, 11 years of age, who had been presented to the Section in November, 1897, had been operated on for the purpose of shortening and straightening the bone, and had again been before the Section in March, 1898, with resulting improvement and ability to walk about. (See The Medical Times and Register, January, 15, 1898, pp. 8, 9, and September 24, 1898, p. 173.—Editor.)

The bones had been found to be solid, the cavity being obliterated. Neither of the patients had received any benefit from antisiphilitic treatment. There was doubt as to the cause of this growth of the bone. It was not improbable that the trouble began in the periosteum. It was a question whether something ought not to be done early in the way of an operation to arrest the process, such as an incision through the periosteum

which might at least relieve the tension.

Dr. T. H. Myers said that this affection was extremely rare. He did not think that any drug could produce a material improvement, though it might prevent further progress of the disease. Such cases were sometimes assumed to be syphilitic for lack of better information, though no history or symptoms of that infection could be elicited.

Dr. V. P. Gibney suggested a linear incision through the periosteum and if that could be done with perfect safety going further by denuding the bone from the anterior surface and shaving off the redundant portion, suturing the periosteum and letting it heal primarily. The growth in length could not be stopped except by attacking the epiphysis, which would be hazardous.

Dr. H. Gibney said that in addition to the treatment which had been suggested he would go further and complete the operation, straightening the leg by the removal of a wedge-shaped piece of bone and maintaining the correct position by plaster of Paris dressings.

Dr. Myers thought that incision would only relieve the pain. He would not operate until the child had attained its growth or the disease had stopped.

Dr. G. R. Elliott said that it was of pathological interest that the tibia alone was affected while the fibula remained normal. There was but little deformity compared with the decided bowing which had been an indication for operation in Dr. Ketch's former patient, in whom the pathological findings were diffusely distributed

throughout the entire thickness of the bone. He asked what effect tying the nutrient artery of the bone would have on the progressive atrophy.

Dr. Ketch said it would probably stop the growth of the bone.

Dr. Elliott suggested the possibility of resulting necrosis.

Dr. A. B. Judson said that if the whole limb were affected symmetry might possibly be promoted during the growing period by checking the vascular supply of the larger limb, by bandaging or lacing the whole limb, and increasing the vascular supply of the smaller limb by venous compression. At the same time the functional activity of the one could be lessened and that of the other increased by the use of an ischiatic crutch or other apparatus having the same effect, with a high sole under the shorter limb. But as the diagnosis was absent and the pathology unsettled he could not suggest a reasonable treatment.

Dr. Ketch said that at an earlier stage some of the operative procedures suggested might have arrested or prevented the abnormal growth of the bone but, on the other hand, they might have promoted it. He was opposed to the removal of a portion of the bone during the growing period. As the parents of the child desired active treatment an incision might be recommended as likely to stop the pain which he thought was due to tension.

#### ENLARGEMENT OF EPIPHYES.

Dr. Myers presented a girl, 16 months of age, whom he had seen for the first time on January 1, 1899. The epiphyses of the radii, femora, tibiae and the entire phalanges of several fingers were enlarged. The joints of the ankles, knees, fingers, wrists and the right elbow were swollen and somewhat restricted in their motions. The enlargement at the ankle joint was peculiar, several of the tarsal bones sharing in it. She walked with difficulty with knees and hips flexed. Flexion of the knees and unwillingness to walk had been observed im-

mediately after an attack of cholera morbus in October, 1898. The knees were kept a little flexed and there was a very slight effusion in these joints. The child did not sleep well but otherwise seemed to be in good health. Potassium iodide, gr. iv-viii, had been given t. i. d. for a month without improvement. The teeth were not notched. There was no syphilitic history. It was not typical scurvy. The child had been for 3 months on a general diet including eggs, meat, potatoes and fruit. It was certainly not a typical case of rickets. She had cut teeth early and walked at 10 months, the head was well-formed and the abdomen not prominent. The diagnosis remained uncertain.

Dr. Ketch said that the obvious feature of the case was a very exaggerated change in nutrition—an overgrowth of some kind, the effect of some not so obvious diathetic cause. He had seen localized changes in scrobutus which were very similar.

Dr. V. P. Gibney said that the changes were similar to those seen in chronic rheumatoid arthritis which he had repeatedly seen in typical forms in children 7 and 8 years of age, and he did not see why it should not attack a child 16 months old. This, however, would not explain the growth of the long bones and phalanges. His first thought was of scrobutus but the condition would have disappeared with the child on the diet stated. Syphilis could be excluded. If pushed for an opinion he would say it was a case of multiple bone tuberculosis, a condition which could be less easily excluded than any of the others mentioned. The boggy feeling of the joints, the fact that there was effusion in the joints and the statement that flexion of the knees and fantum all supported the view that it an unwillingness to walk had followed an attack of cholera infantum all supported the view that it was an instance of bone tuberculosis. He would raise the question whether synovitis was not one of the earliest

signs of tuberculosis in a child. He advised putting the child in a wire cuirass and keeping the limbs extended. It was not good to allow the child to walk.

Dr. Ketch said that primary synovial tuberculosis was rare in children.

Dr. Judson had noticed the contraction of the knees and hips but thought it was not the result of the reflex muscular action of joint disease and that the fact that the contractions were nearly symmetrical pointed to a more general cause than tuberculosis of the joints affected. He did not think that synovitis was an early incident of osteitis, and that primary synovitis could be differentiated by the absence of the usual signs of osteitis, which were muscular atrophy and reflex action and a prolonged history of inconstant lameness and pain. Synovitis should not be considered as liable to run into osteitis. Although, practically, it was well to relieve a synovitic joint from weight-bearing.

Dr. Ketch said that he had rarely seen synovitis as an early sign of tuberculosis.

Dr. V. P. Gibney said that the focus of diseased bone might suffer a traumatism and thus cause an extension of the process and give rise to this outward manifestation. He recalled a case seen twenty years ago. The child's knee was full of fluid. It was thought surely to be synovitis and a glowing prognosis of recovery in a few weeks was made, but after 6 or 7 years' treatment recovery took place with a stiff knee. Primary osteitis with secondary synovial distension occurred before the gross signs of the osteitis which called the attention of the practitioner to some trouble in the knee. At this stage the trouble could be cured.

Dr. Elliott said that fluid in a joint immediately after a traumatism pointed clearly to a synovitis directly due to traumatism. If tuberculosis followed it resulted from a further injury to the bone itself which made a proper nidus for the tubercular

growth. In other words a dual injury and the fluid in the joint was entirely distinct from the true tubercular lesion and in no way connected with it. The later tubercular development might delay the absorption of the primary synovial excess and thus the latter might come to complicate the tubercular joint.

Dr. Myers had seen effusion early in tubercular joint disease but did not consider it of diagnostic value. In spite of the fact that the patient had had, apparently, an anti-scorbutic and antirachitic diet he could not help thinking that the trouble was due to one of these diseases rather than to tuberculosis. The child was not very sick. The principal changes were in the epiphyses and phalanges and seemed to him to be due to some form of nutritional disease. The congested epiphyses could fully account for the pain and tenderness, but he would adopt the suggestion made and protect the joints by keeping the child quiet.

#### CASES OF COXA VARA.

Dr. Myers also presented a boy, 8 years of age, who had waddled, and was walking worse every years, since he began to walk. His muscles were strong. A certain rigidity of all the muscles of the lower extremities made examination somewhat difficult. The motions of the hip joints, especially flexion and the abduction were somewhat limited. There was no dislocation, but the neck of the femur was seen in the skiagram to be bent down as in coxa vara. The diet had been very good. The boy was a little bow-legged and flat-footed.

Dr. Gibney found no shortening and trochanters but slightly above the line. He thought the waddling might be due to the flat-foot.

Dr. V. P. Gibney said that the radiograph showed forward rotation and a little bending backwards of the femoral neck at its junction with the shaft.

The opinion was expressed by several speakers that the boy had coxa

vara in a mild and not strictly typical form.

Dr. Elliott thought that the condition dated from early rachitis in all probability. The picture was a logical one and the femoral neck had changed simultaneously with the bowing of the legs, both having been more or less plastic.

Dr. Ketch said that the traces of rachitis were obvious. Coxa vara was sometimes made to include cases that were not dependent on bending of the bone. Some cases were due to deviations caused by abnormal epiphyseal growth resulting in a change in the angle of the neck of the femur. On the other hand the peculiar gait of coxa vara was not infrequently attributed to knock-knees or bow-legs.

Dr. Judson said that coxa vara might be considered to mean an abnormal, or various relation of the neck of the shaft caused by lesions of different kinds all of which were not yet recognized.

Dr. V. P. Gibney said that in coxa vara we had found one new disease or condition to rule out in our study of hip disease. Many cases of "hip disease" in adolescents which recover and have relapses, but never get very bad, having from 1-2 to 3-4 in. shortening, were really cases of coxa vara.

Dr. Ketch presented a boy, aged 11 years, who had had a limp (left leg) in winter but not in summer, for three years. Pain and inability to walk on rising; disappeared entirely in the afternoon. There had been no history of rickets or rheumatism. Abduction was limited, especially in flexion. Outward rotation abnormally free, trochanter 1-2 in. above the line, no atrophy. R. 28, L. 27 5-8. The skiagraph showed a change in the angle of the neck.

#### TREATMENT OF COXA VARA.

Dr. Judson suggested mechanical means for permitting locomotion while the affected part is relieved from the weight of the body as long as the bone was in a growing or plastic state.

Dr. V. P. Gibney said that when the

affection was single, good results could be obtained from the use of the hip-splint. He saw no objection to the wearing of a jointed splint for some months, affording, not absolute but modified, protection, enough to shut out traumatism.

Dr. H. Gibney said that the ischiatic crutch for this purpose was easily adjusted and comfortably worn and allowed the limb to hang free.

Dr. Myers said that when both femora were affected, mechanical protection was attended with difficulties, and it was not easy to keep the adolescent patient, like the one he had presented, quiet.

Dr. Judson suggested the use of a bicycle.

Dr. Ketch in such a case would improve the general nutrition and prepare the parents for a long wait.

#### PAIN RELIEVED BY TRACTION.

Dr. Myers related the history of a patient, 26 years of age, who had suffered 5 1-2 years from rheumatism in the ankles, neck, shoulders, elbows and wrists and the right hip. For the first year improvement had followed massage and medical treatment. For the past 4 1-2 years the right hip had gradually become stiff and painful in walking. When first seen by Dr. Myers in February, 1898, there was some spasm but no shortening. Motion of hip: flexion 16 degrees; abduction 10 degrees; external rotation 10 degrees. A short traction hip-splint was at once applied and is still worn. There had been no pain since June, 1898, and the man considered himself greatly improved.

Dr. Ketch recalled the case of a man in whom the terrific pain of a sarcoma of the femur had not been relieved by powerful narcotics but had been relieved for a time by traction made with a long hip-splint and afterwards, as more convenient, with a short splint.

#### FRACTURE OF NECK OF FEMUR IN AN INFANT.

Dr. Myers showed a specimen of fracture of the neck of the femur in a child, 8 months old. A large amount

of callus was present within and without the periosteum. There was a lateral displacement of the lower fragment inward one-third the diameter of the bone. There was no change in the length of the bone. No history could be obtained except that the injury must have occurred before the fifth month.

#### A NEW PELVIC REST.

Dr. Myers also showed a pelvic rest, especially well suited for the application of spica bandages which included the trunk and thighs, as it could remain in place until the spica was fully applied and could then be easily withdrawn. It was made of a piece of sheet steel, 1-4x1 -2x14 inches, bent upon itself so as to form three sides of a square. The ends were hammered out so as to form oblong lanes about 3 inches broad and 5 inches long. When in use one of the planes rested upon the table and the other supported the sacrum while the upright connecting them was directed towards the feet.

#### MEETING OF MARCH 17, 1899. LATERAL DEVIATION OF THE SPINE AND PES CAVUS IN FRIED- REICH'S ATAXIA.

Dr. W. R. Townsend presented a boy, 2 years of age. Since an attack of scarlatina at the age of 7 his nutrition had been very poor. The first signs of ataxia were an unsteady gait and inability to keep from falling if pushed. For the past 7 years he had had frequent pain in the knees. Lateral curvature of the spine appeared 3 years ago and has steadily increased, a long curve to the right extending from the 9th dorsal vertebra downward, with rotation. A plaster of Paris corset had been applied with moderate suspension. There was pes cavus but no equinus. The gait was markedly ataxic. Standing with feet separated and eyes closed there was swaying of the body. The patellar reflexes were lost. Speech was slow. There was nystagmus but no Argyle-Robertson pupil.

Dr. J. Collins said that it was a clinically typical case. In addition to disease of the posterior columns there was sclerosis of the lateral parts of the cord including the direct cerebellar tracts shown in persistent efforts of the patient to balance himself and producing the peculiar condition; found in every case and heretofore undescribed, aptly named the fork-prong condition of the extensor tendons, the feet being in continual balancing action with the tip of the toes dipping into the substance of the floor. The dynamic deformities which later became static were the result of some connate lack of development in the anisotropic muscular substance. The deformity might be explained by postulating the existence of some congenital incapacity of development, some abnormal condition of the proton of the muscular substance. The disease was progressive and usually uniformly so and might extend through half a normal life-time. There was something attractive about the theory that some fibres of the spinal cord might have suffered death 50 or 60 years before the normal time, a death without active inflammatory or degenerative changes and akin to that which attended senility. The plaster of Paris corset could have no influence on the disease but it had in his experience, contributed to comfort. A potent agent in restoring the function of the muscles was the re-education of the extremities. The patient might be so taught that in a few months he would be able to walk into the room without perceptible disturbance of gait.

Dr. S. Ketch said that the association of nervous disease with lateral curvature was suggestive. Many features of the latter affection could not be explained except by the presence of some prior defect in the nervous system. The case came near being an argument for the neural etiology of lateral curvature.

Dr. H. L. Taylor said that the argument was not convincing. The coincidence of nervous disease could not

establish the neuropathic origin of lateral curvature which we saw also in collapse of the lung without rating pulmonary disease as an important etiological factor.

Dr. A. B. Judson said that a nervous origin was not altogether improbable from the observation that the curvature appeared to be due to inability of the muscles to sustain weight while the muscular failure seemed to be the result of faulty innervation.

Dr. Ketch said that in the absence of a demonstrable etiology he would adhere to the opinion that a large number of cases were caused by an antecedent fault in the nervous system.

#### CONGENITAL DEFORMITY OF THE LOWER EXTREMITY.

Dr. Ketch presented a girl baby, 2 months old, with great bony deformity of the right lower extremity. There was shortening and twisting of the upper end of the femur and all the bones were smaller than those of the left leg. The fibula was indistinct, giving only the feeling of cartilaginous hardness. The place of the patella was marked by a slight immovable eminence. There was marked equinus with inversion, the motion of the knee was greatly limited in extension and the spine was slightly deviated to the left in the lower dorsal region. There was dimpling and adhesion of the skin to the outer side of the lower end of the femur. The head had presented in an easy labor with the cord wound around the body so that it held the right foot on the left buttock, "so tightly bound there was no blood in the leg until an hour." The cause of the deformity was evidently retention of the parts in the foetal position by pressure of the cord, the limb being unable to escape and develop normally.

Dr. Taylor said that the bones were all present, but the fibula seemed to be fully developed only at its lower end, and the deformity of the foot was not the one usually associated with absent fibula. In these cases some bone was usually lacking or rudimentary.

Dr. V. P. Gibney said that the clear history explained the cause of the deformity. He recalled the case of a child born with dislocation of both hips and both knees, arrest of development being found at the knees, and double club-feet of an exaggerated type. The elbows were defective and the movements of the shoulders rather limited. Repeated operations had been required with plaster of Paris retention, and as a result the patient had for several years been walking about and going to school without apparatus or any other assistance. He had under observation another child with prenatal amputation of several fingers and double club-foot which arrested tibial development. The fibulae being very much elongated he had divided them obliquely about 2 inches above the malleoli and slipped the distal portion up on the proximal thus bringing the foot into a very good position.

#### CONGENITAL LATERAL CURVATURE OF THE SPINE.

Dr. R. Whitman presented a girl, 7 years of age, whom he had first seen when she was 9 months old. She then presented a well marked rotary lateral curvature of the spine that had been noticed by her mother immediately after birth. In spite of the application of braces and manipulation the curvature grew worse rapidly until two years ago when the tiltings of the pelvis was so extreme that there appeared to be marked inequality in the length of the legs. The degree of the deformity was seen in a Roentgen picture. Since that time she had been under treatment by irremovable plaster jackets, applied with as much corrective force as could be borne, with most gratifying results. The pelvis became level and the limp had disappeared. The spine had become flexible and its deformity had been in great part corrected. This method of forcible correction and retention in severe curvatures of this class in young children appeared to offer the best chance of ultimate success.

Dr. G. R. Elliott said that the child's

head, shoulders, hips and lower extremities were developed far beyond the thorax as one of the results of two years' encasement. The plaster of Paris jacket is advisable in proper cases but it should be renewed once in three months and should be removed at least weekly to permit breathing exercise and massage.

Dr. R. H. Sayre said that bad effects do not necessarily follow prolonged treatment in the plaster jacket. He recalled the case of a boy affected with rachitic lateral curvature who was unable voluntarily to stand in an upright position. He was kept in solid plaster of Paris for a period of three years. When the jacket was removed treatment to develop the muscles restored them to as good condition as the muscles of the rest of the body.

Dr. Taylor said that he did not hesitate to immobilize joints and their acting muscles for years if necessary to arrest disease. He had never seen a case in which, after such treatment, the muscles were not developed to the limit imposed by joint motion. It had been demonstrated clinically that when motion was restored to knees ankylosed for many years the muscles assumed their functional activity.

Dr. Ketch said that atrophy of muscles and stiffness of joints caused by the application of plaster of Paris or a brace were of no serious moment and were followed by no ultimate bad effect.

Dr. Elliot believed that permanent injury followed prolonged confinement of children in plaster of Paris forcibly applied. He had a patient under treatment who had been thus treated for 7 years and was as a result a hopelessly bedridden invalid. It might be an exceptional case, but with a neurathenic temperament and enfeebled muscles present the injury would extend beyond the possibility of rehabilitation. The muscles might revive but the bones and cartilage of the thorax would be atrophied to the

ultimate impairment of the heart and lungs.

Dr. Townsend suggested that the same improvement might have been secured if the jacket had been replaced by a firmly applied corset whose occasional removal would have permitted the employment of massage.

Dr. Whitman said that the child had worn a brace which the mother was instructed to remove and give the child massage but until the jacket was applied as described the patient grew steadily worse.

#### THE EFFECT OF GYMNASTIC EXERCISES IN REMEDYING THE DISPLACEMENT OF THE HEART IN LATERAL CURVATURE.

Dr. T. E. Satterthwaite presented a paper to the effect that the malposition of the thoracic and abdominal viscera which attended well advanced cases of lateral curvature might be considered as a constant menace to health, and it could be inferred that the thoracic pain of this affection, due in some patients to neurotic conditions, was due in others to the faulty position of the heart which was generally displaced towards the concavity. He presented a curvature toward the right in the dorsal region of the spine. The pelvis was tilted and the left breast was prominent. When first seen in the summer of 1898 she was pale, anaemic and short-winded. The heart's action was weak and the apex 1 inch to the left of the nipple. After 3 months' treatment with resistant exercises, electricity, gymnastics and massage the anaemia was corrected, the heart's action was improved and the apex was well to the inner side of the nipple line. Its change in position was traced in diagrams taken successively during the progress of treatment. Two other patients were presented with similar histories and with diagrams showing the migration of the apex during treatment and coincidently with the improvement in the general and local condition of the patient. These patients illustrated in person a long series of the appropriate

exercises in many of which indicated muscles were called into action by resistance applied by a medical attendant. The exercises were taken by the patient standing erect, leaning against a support, sitting, recumbent, semi-recumbent or suspended by the hands. In the majority of cases there was an advantage in combining force for the reduction of the deformity with some of the prescribed exercises and manual force should be applied without the assistance of mechanical apparatus. Double pressure should be made when practicable, one hand being placed upon the dorsal convexity and the other on the lumbar convexity each pressing towards the spine. As a rule tonics or nutrients were required; iron, strychnine, cod liver oil and malt extracts. Massage of the muscles of the back was a valuable adjuvant and the Faradic current might be applied successfully during the entire course of treatment, employed so as to contract actively the muscles of the back. An effort should be made, where practicable, to do away with the spinal brace which should be advocated only as a temporary expedient or in cases in which all other measures had failed. By pursuing a more thorough and painstaking course than that commonly in vogue the heart and with it the lungs and in time the abdominal viscera might in a measure be restored to their natural position.

Dr. Sayre said that inspection of a preparation of lateral curvature showed that suffering from impeded action of the heart and lungs probably attended cases of well marked deformity. As a rule, however, such patients were not prone to die of disease of the heart or lungs and, although perhaps somewhat disturbed, they lived to a good old age. He had seen distinct relief of shortness of breath from treatment by exercises and patients in whom the rapidity of the heart-beat had been materially reduced. In one case the pulse rate came down from 120 to 90 when suspended and 106

when in a plaster of Paris jacket. He had a patient under observation in whom a murmur, distinctly audible at some distance and in certain positions of the body, and sounding very much like a tin whistle, had disappeared under the influence of exercises.

Dr. Satterthwaite said that the murmur has been probably due to anaemia and a flabby condition of the chambers and ostia of the heart. He did not think that cardiac displacement in these cases gave rise to abnormal sounds, extrinsic or intrinsic.

Dr. H. S. Stokes said that he thought it was very difficult to say whether the position of the heart had changed or not. It was the opinion of some observers that the heart could not be accurately mapped out during the life of a normal chest. In a chest deformed by lateral curvature the element of possible error must certainly be a large one. In his observation the result of treatment had been an improvement in the general condition of the child and the prevention of an increase of the deformity rather than an obliteration of the curvature.

Dr. Satterthwaite said that while many physicians among the Germans and English rejected methods of mapping out the heart, in this country observing the heart in this manner was accepted as practicable and important. He believed that it was easy to determine the position of the apex by the impulse and also by the use of the stethoscope.

Dr. J. Teschner said that the heart could not be directly affected to an appreciable extent unless the deformity was so great as to crowd and displace it. He had not mapped out the heart in his cases but its change of position as the result of treatment by heavy gymnastics had been obvious. In a girl, 19 years of age, a very severe rotary lateral curvature of at least 10 years' duration was combined with cardiac trouble dating from acute articular rheumatism and peri and endocarditis at the age of 4. There was marked hypertrophy and dilatation, a

double aortic murmur, a double mitral murmur and a very decided murmur over the pulmonary with the second sound. The murmurs were very widely transmitted. Dyspnoea was marked. Slight cyanosis at rest became marked on the slightest exertion. The heart had been growing rapidly weaker, oedema had appeared and her physician believed that she would live only a year or two longer. Beginning with very gentle exercises, in 6 months she was practicing heavy gymnastics and her physician expressed surprise at her improved condition. He found the heart smaller and changed in its relative position to the chest wall and none of the murmurs except the pre-systolic mitral transmitted to the side and back as before. Dr. Teschner believed that the deformity could be reduced by the voluntary and resisted efforts of the patient and not by external force. Electricity and massage were valueless when compared with voluntary exercise. The more the patient exercised the muscles through the medium of the will the greater would be the benefit. He thought that the exercises described and exhibited fell far short of what was required and that their effect in severe cases would be like that of an infinitesimal dose of a drug whose full physiological effect was desired. He thought that one curve could not be modified without a corresponding effect on the compensating curve. The trouble was not the deflection of a single vertebra but of several, leading to the production of the sigmoid deformity.

Dr. Satterthwaite agreed that the different curves should be considered together as making up the deformity and added that in the treatment the muscles should be also considered together, as it was impossible to exercise or develop one group or muscle without acting on all the muscles of the region.

Dr. Taylor said that while electricity and massage were good they were not sufficiently good to cure lateral curva-

ture. Reliance should be chiefly on muscular training and suitable apparatus. He would welcome any possible way of dispensing with apparatus which, useful in selected cases, left much to be desired. The hygiene of the patient was of great importance. The physician should regulate the food, schooling, exercise and rest. Piano playing was a pernicious occupation for a patient with a weak back. It should be moderated and usually stopped. One of the things which had held us back in the treatment of this affection was the difficulty in measuring and recording changes which take place. The position of the heart might perhaps in some cases be a useful indication. Measurement of the height from time to time was more easy and likely to furnish more reliable observations.

Dr. Satterthwaite said that he was in the habit of recording the height as a routine matter but in growing children such measurements might be misleading.

Dr. Ketch said that apparatus was of value in retaining the improvement gained through exercise which when properly conducted produced a good effect on the deformity and indirectly on the condition of the heart, for there was no doubt that the changes in the vertebrae themselves and in the chest walls and the diameter of the thorax gave rise to changes in the viscera. As long as rotation persisted no case of lateral curvature could be said to be really cured. This was always a menace and liable to increase and was the more difficult element to control. The bony changes which followed the muscular changes also made the treatment of lateral curvature very difficult. Curvature depending on simple muscular weakness was the easiest to control, but these were not cases of true rotary lateral disease. Each man should work out his own ideas in regard to the question of exercises, remembering that no form of treatment would be of the slightest value unless it was continued for a long time.

Dr. Satterthwaite agreed that not all cases were suitable for the treatment which he had described. It could not easily be made successful in the case of out-patients, especially those who lived far away and thus were unavoidably irregular in their attendance. The patients presented were all improving in general condition, the spine was gradually moving forward towards the normal position while the heart in each had taken an improved position.

#### A PELVIC REST.

Dr. Townsend exhibited a simple apparatus to facilitate the application of a plaster of Paris spica to the hip. It held the pelvis and thigh up so that the roller might be conveniently passed between the patient and the

table and when the application was made and set the thin steel shelf on which the pelvis rested might be readily withdrawn from between the bandage and the patient. It was similar in action to the rest shown by Dr. T. H. Myers at the last meeting of the Section. The standard or vertical part,  $6 \times 1$   $1-4 \times 1-4$  in. was forged at its upper end into a thin horizontal shelf  $10 \times 2$  in. and at its lower end it was bent at a right angle to form the bar, 11 in. long, which rested on the table. The cross-pieces, 11 in. long, of lighter steel were provided with mortises by which they could be removed for packing or adjusted by sliding them along on the bar until they were in position to hold the apparatus firmly, without rocking, on the table.





## Editorial

THE MEDICAL TIMES AND REGISTER is published monthly.

All communications, reviews, etc., intended for the editor should be addressed to 367 ADAMS STREET, DORCHESTER, BOSTON, MASS.

THE MEDICAL TIMES AND REGISTER is published by The Medical Publishing Co., 717 Betz Building Philadelphia, Pa., to whom all remittances should be made by bank check, or postal, or express money order.

Subscription price is \$1.00 a year in advance. Foreign countries, \$1.50. Single copies, 10 cents.

Advertising rates may be had on application at the Philadelphia office.

Original articles of practical utility and length are invited from the profession. Accepted manuscripts will be paid for by a year's subscription to this journal and one hundred extra copies of the issue in which such appears if desired.

Reprints of Original Articles are not furnished except on payment of cost price by the author.

Entered at the Philadelphia Postoffice as second-class mail matter.

---

### MANIPULATION OF THE BOWEL AND THE CONSUMPTION OF TIME IN LAPAROTOMY.

It is curious to note from time to time the slow and jerky evolution of some of the fundamental principles in surgery, and how in time some of the dogmas get the back-door. Flushing, flooding and water-logging everything that was scratched with a scalpel has gone, though not until it had destroyed a hundred for every one it saved. The drainage-tubs has gone with it, although this was a more subtle agent of destruction.

Then came abdominal surgery the idea that once the peritoneum was opened "we must get out quickly." This principle cost thousands of lives. We were warned to be cautious "not to handle the intestines only as little as possible lest we aggravate shock," but it has recently been demonstrated that the squeezing of the paretic intestine seems to act as a stimulant to the muscular coat and at the same time

the vessels are relieved from an excessive engorgement.

Certainly no time should be lost in tinkering, nor should one tarry after signs of shock set in, but neither should one ever close the peritoneal cavity, hermetically, until assured beyond doubt that we have properly performed our task. It is much better to do an incomplete operation and then, later, when constitutional conditions permit, to proceed and finish in a proper manner what was undertaken first.

This is well illustrated in cases of intestinal obstruction. In some we may empty, resect or release the bowel all at once, the condition of the patient permitting it; again, we must be content to simply tap the bowel and drain off the feces, leaving the completion of the work until full reaction is restored and the constitutional condi-

tion of the patient warrants it. This was well illustrated in a recent case recorded by Delbet in an operation for cancer of the entire descending colon, sigmoid and rectum.

This remarkable surgeon finding his patient in a deplorable physical condition was content at first to simply open the belly, draw out the splenic loop and make an artificial anus.

Immediately all distress disappeared and the patient commenced to put on flesh. When full health was practically restored, except for the local malignant disease, Delbet reopened the abdomen, the pelvis and peritoneum and removed the whole of the colon, rectum and anus, his patient making an excellent recovery.

When once in the peritoneal cavity, in a warm room and our patient in good condition and losing no blood,

there is no more danger from consuming a whole hour than in a five minute exposure.

This is not an over-drawn picture, but one realized by every surgeon who now operates with security and leisure rather than with the rush and bustle of former times when he hurriedly closed the abdomen after a hotch-potch operation hurriedly performed.

Abdominal surgery requires from its votaries, exactness and precision in every detail no matter how insignificant. These things must be attended to with skill and deliberation when we may be assured of successful results, assuming that the operator has shown good judgment in the selection of his cases and that after-treatment is always what it should be.

T. H. M.

#### HYSTERECTOMY AS A CONSERVATIVE OPERATION.

The above is the title of a highly important contribution from the pen of Mr. Bland Sutton, who is widely known as a surgeon of advanced reputation on the treatment of diseases of the female genitalia. He begins by observing in the British Medical Journal that: "The title of this paper is sufficient to excite anxiety in the minds of physicians practicing midwifery. There need be no alarm; its object is not to advocate hysterectomy, but to demonstrate the effect which a reliable observation often exercises on the theory and practice of surgery. It is very remarkable that the health of a woman during the sexual period of life suffers less from the loss of her uterus (when it becomes necessary to carry out such a dreadful measure) than after the complete removal of the ovaries. This fact is producing extraordinary modi-

fications in the treatment of diseases of the uterus, Fallopian tubes, and ovaries.

#### THE UTERUS A HOLLOW MUSCLE.

The uterus is structurally a muscle of the unstriped variety, containing, as is usual with this kind of muscle, a central space lined with mucous membrane; in this instance, it has peculiar characters, and is known as the endometrium. The hollow muscles are distinguished from the solid voluntary species by the fact that they act independently of the will, and undergo more or less rhythmic changes commonly known as dilatation and contraction, but in physiologic terms are expressed as diastole and systole. These movements are concurrent with the presence of fluids or solids within the cavities of these muscles. Thus in the esophagus it is food or drink; in the heart and spleen, blood; in the

ureter or bladder, urine, and so on. The duration of the cycle differs in all; in the heart the beat happens many times (70) each minute; in the ureter a few (5) times to the minute, whereas the bladder requires three or more hours; in the rectum as a rule the cycle lasts a day, whilst in the uterus it occupies three-fourths of a year with a long interval for rest.

In nearly all cases the contraction (systole) may be abnormally excited, and when accentuated produces pain of a peculiar character called cholic. In the case of the heart, such intensification of the systole usually terminates in death. The uterus is singular among hollow muscles not only in the excessive length of its cycle or beat, but also in the fact that its epithelium is shed with great regularity once a month (menstruation) save when it is occupied by its long dyastole, that is during pregnancy."

Shades of Battey and the days of conservative surgery! Under what a spell the timidity and stupidity the profession for ages must have labored if the position of Sutton cannot be assailed?

It won't do to allege that antisepsis made possible and safe the extraction of the uterus for Dr. Granville Bantock, the distinguished operator at the Good Samaritan Hospital, has recently demonstrated that the antiseptic method is a "harmless myth."

No wonder, indeed, that a facetious writer in a lay journal, in a recent defense of charlatans, declares that

"medical authorities of each succeeding age are chiefly concerned in nullifying the fraudulent doctrines propagated by a preceding generation."

But, however we may view it, every one who is at all familiar with frequent unfortunate sequelæ which follow oophorectomy must hail Sutton's essay as the most important and valuable one given to the profession in many years.

He begins by showing us that the removal of the uterus by Baer's method entails no loss of anything vital to life; propagation of the species only being arrested, ovulation and full sexualization being fully preserved. However, it would be interesting to enquire here if, with the uterine cervix preserved, and the ovaries in full activity there is not a great probability of abdominal pregnancy following after copulation, the fecundated ovum seizing on any vascular surface?

Modern surgery has certainly sent Battey's operation into the eternal shades of oblivion in the treatment of uterine fibroids, and it has demonstrated that, in the hands of any capable operator, hysterectomy per se is by no means a very formidable procedure. Sutton has shown that the ovaries serve other important functions in the economy besides providing menstrual ova and that under all circumstances it is of the greatest importance to spare them entire, or that portion of the stroma which is in a healthy state.

T. H. M.

---

A COMPETITIVE examination for the position of Second Assistant Physician and Pathologist to the New Jersey State Hospital for the Insane at Trenton will be held in the Trenton House, Trenton, N. J., on Saturday, July 1<sup>st</sup>, prox., commencing at 10:00 o'clock a. m. Candidates will be examined in the or-

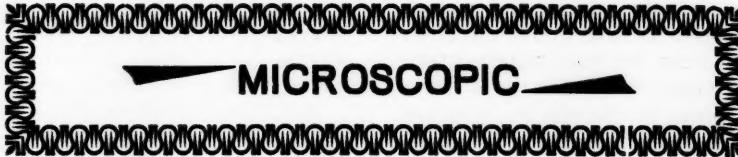
der of application. For conditions, requirements, etc., address Medical Department, Box 258. Trenton, N. J.

HENRY R. BALDWIN,

N. NEWLIN STOKES,

*Medical Committee.*

State Hospital, Trenton,  
June 2, 1899.



## MICROSCOPIC

### GENERAL METHODS IN BOTANICAL MICROTECHNIQUE.

#### CUTTING SECTIONS.

The sections must be cut on a microtome. Cut one of the objects with a suitable amount of paraffin out of the cake by means of a sharp scalpel, taking care that the edges of the block will be parallel with the general contour of the object. Trim the block down to a rectangular shape and fasten it to a block of wood, or a special holder which goes with some microtomes. Before attempting to fasten the block to the holder, have the top of this covered with a cushion of paraffin. The paraffin block must be fastened firmly, and the edges especially sealed with a hot needle so that there will be no danger of having it come off. After having cooled off the block in cold water and trimmed the sides to be parallel, fasten it into the clamp of the microtome and adjust the knife and clamp so that the knife will strike the paraffin block perfectly parallel. The ribbon of sections should be straight and not coiled. If the ribbon coils, no good mounts can be made even if everything else has been satisfactory so far. The desirable thickness of the sections depends somewhat on the nature of the material and the object to be attained. As a general rule most sections may be cut ten microns ( $\mu$ ) thick. The section knife or razor must be sharp and clean, with no trace of the smallest notches, at least in that part with which the cutting is done. It is well to examine the edge of the knife under the low power of the microscope to see that it is in good condition. After the ribbon has been cut care should be taken to have all the

pieces arranged in a continuous series, from left to right, on a clean sheet of paper. The sections may be covered with wide bell jar. If the sections do not hold together well while cutting, the paraffin may be too cold or there may be other defects. These should be discovered and removed before proceeding further. Ribbons should be cut yards in length, without a single break, when serial sections are cut.

#### MOUNTING.

1. Take a clean slide and put a spread it out over the surface with the small drop of albumen fixative on it. finger into a very thin, even layer, being careful that no part of the finger touches the slide before being covered with a layer of albumen. The layer must be quite thin so that you can just leave noticeable impression of your finger on it. Too much albumen will ruin the preparation. The albumen fixative is made as follows:

1. 25 cc. of the white of a fresh hen's eggs.
2. 25 cc. of glycerin.
3. 0.5 gram sodium salicylate.

Shake well and filter. This will keep well for at least six months.

2. Now lay the slide down on the table and put a few drops of distilled water on it, on top of the albumen film. Care must be taken here that that the water will not flow over the edge of the slide.

3. Cut the ribbon into suitable lengths, according to the size of the square or oblong cover-glass, discarding the ends of the ribbon which do not contain sections. With a scalpel lay the pieces of ribbon on the water in the center of the slide in such a manner that one may begin at the upper left-hand corner and follow the

sections in lines, as one reads the words on this page. Allowance must always be made for a certain amount of stretching of the ribbons when they are heated, as they are always more or less ruffled. Never press the sections down with the finger or by any other means, else the fine structure will be broken and distorted.

4. Warm the slide gently by putting it on the paraffin oven until the heat has straightened out the sections on the water, but do not let the sections get so hot as to melt the paraffin out slides may now be placed on wooden blocks, which may be kept constantly on top of the oven for this purpose. It is best to let them remain for about twelve hours, when the water will all be evaporated and the sections firmly dried to the slide. Four, eight, or more slides can be carried through at one time just as well as a single one.

#### STAINING.

The sections are now ready for the staining. One must have the following Stender dishes:

1. Filled with turpentine.
2. Filled with xylol.
3. Filled with absolute alcohol.
4. Filled with 95 per cent. alcohol.
5. Filled with 85 per cent. alcohol.
6. Filled with 70 per cent. alcohol.
7. Filled with 50 per cent. alcohol.
8. Filled with 25 per cent. alcohol.
9. Filled with distilled water.

The various stains used may also be kept in Stender dishes if no special staining dishes are at hand. The following stains are recommended for general purposes:

1. Anilin safranin, alcoholic (50 per cent.) solution, made by combining equal parts of anilin water and a saturated alcoholic (95 per cent.) solution of safranin. The anilin water is prepared by shaking up anilin oil in distilled water. About 3.5 per cent. of anilin oil will be taken up by the water.

2. Gentian violet, a 2 per cent. aqueous solution.

3. Iron alum, 2 per cent. aqueous solution of ammonio-sulphate of iron.

4. Hæmatoxylin, a 0.5 per cent. solution obtained by dissolving in hot water.

The remaining Stender dishes will therefore be as follows:

10. Filled with anilin safranin.
11. Filled with gentian violet.
12. Filled with iron alum.
13. Filled with hæmatoxylin.

#### FIRST STAIN—ANILIN SAFRANIN.

1. Melt the paraffin around the sections of two slides by heating them to 50° C. in the paraffin oven.

2. Wash off the paraffin by putting the two slides back to back into the Stender dish with the turpentine.

3. Transfer to Stender dish of xylol.

4. Next put them in succession into the dishes with absolute alcohol, 95 per cent., 85 per cent., 70 per cent., and 50 per cent. Let them remain in each one about ten seconds, more or less. Do not leave the dishes uncovered longer than necessary.

5. Transfer the slides from the 50 per cent. alcohol to the anilin safranin dish, and let them strain from two to four hours.

Note.—In taking sections from xylol to any stain, always pass down the grades of alcohol until the sections are in the same grade as the stain, and then transfer to the stain.

6. When the sections are stained wash them successively in the 50 per cent. alcohol, 70 per cent., 85 per cent., 95 per cent., and absolute alcohol. Judgment must be used as to how fast the transfer is to be made from one grade of alcohol to the other. They must generally be taken quite rapidly, as the alcohol will take out such stains as safranin.

7. Clear the sections by transferring them to the xylol. The sections must be thoroughly cleared. Leave them in xylol until they look transparent.

8. Take one slide out of the xylol at a time; wipe off the xylol with a clean rag, wiping quite close to the sections, but do not touch the sections.

9. Put a drop or so of Canada balsam (dissolved in xylol) on the sections at one side.

10. Put on a clean cover-glass in the following manner: holding the cover-glass with the edges between the thumb and forefinger, bring it down slowly and obliquely upon the drop so that one edge of it is first wetted by the balsam; and supporting the opposite edge with a needle, let the cover gradually settle down and spread out the balsam. There should be no air bubbles and just enough balsam to come to the edge of the cover-glass. Care must be taken to not let the sections become dry at any stage of the foregoing process. The slides may now be laid aside into a convenient place to dry. They may be studied immediately if handled with care for a few weeks until the balsam has thoroughly hardened around the cover-glass. If any balsam should get on the hands or instrument, it can be easily removed with a little xylol.

**SECOND STAIN—ANILIN SAFRANI,  
GENTIAN VIOLET.**

This makes a good double stain for many purposes. Stain first in the anilin safranin from two to four hours; then wash in 25 per cent. alcohol; next in water; and then stain from one to four minutes in the gentian violet. After washing in water, pass through the grades of alcohol, clear in xylol or clove oil, and mount in balsam.

**THIRD STAIN—HEIDENHAIN'S IRON-  
ALUM-HAEMATOXYLIN STAIN.**

Run the slides down to water, and from this transfer to the iron-alum. Keep the sections in this from two to four hours, and after washing well in tap water, stain for twelve hours (or over night) in the haematoxylin. After this wash the slides again in water and wipe them clean, and as close to the sections as is safe. The

sections are now black and must be cleared. To do this they are placed again in the iron-alum, which gradually takes out the excess of stain. They must be closely watched and examined from time to time under the low power of the microscope. When of a light greyish-blue color they are washed again very thoroughly in tap water so that all iron salt is removed, and are then carried through the grades of alcohol, cleared in xylol, and mounted in balsam.

**FOURTH STAIN—ANILIN SAFRANIN,  
IRON-ALUM-HAEMATOXYLIN.**

After one has become accustomed to use the foregoing combinations successfully, the following is well worth trying. Stain first in anilin safranin or in anilin safranin and gentian violet, as described above; wash in water; and then stain in the iron-alum-haematoxylin according to the directions given, just as though the sections had not been stained at all. After staining, removing excess of stain, and washing in tap water, pass through the grades of alcohol, clear in xylol, and mount in balsam. This is one of the clearest stains I know of.

There are many other excellent combinations and stains, all of which should be learned gradually and employed. The person who uses but one method of killing and staining without trying others and comparing them, may get certain results, but such results are always to be taken with some reserve. The stains mentioned above, it is believed, will give quite uniform and satisfactory results for general purposes, and they may be taken as the starting point for acquiring a technique which is both elaborate and extensive.

—John H. Schaffner in *Journ. of Applied Microscopy.*

## CLINICAL SURGERY AND SURGICAL PATHOLOGY.

In Charge of T. H. MANLEY, M. D., New York.

ON SURGICAL DISEASES OF  
THE KIDNEY.A CLINICAL LECTURE DELIVERED  
AT CHARING CROSS HOSPITAL

BY JOHN H. MORGAN, F.R.C.S.,

Surgeon to the Hospital; Senior Surgeon  
to the Hospital for Sick Children, &c.

(Extract.)

It would, perhaps, be difficult to assert that the surgery of any one part of the body had advanced with much greater strides than that of another during the past fifteen or twenty years; still more difficult would it be to show that the operative procedures on any one of the organs included in the abdominal cavity had surpassed in magnitude and in results those performed on other parts of equal importance; but it will hardly be asserting too much to say that although much greater perfection may yet be attained both in the diagnosis of causes and in selection of procedure, the surgery of the kidney has developed during this period to an extent which seems almost appalling to those who studied surgery before that era. Since the time that surgeons have learnt that with proper precautions the peritoneum may be treated almost as freely as superficial parts, the organs which it surrounds, or with which it is in contact, may be dealt with both for the purposes of diagnosis, or for remedying effects which are the result of disease.

Thus there have been developed various proceedings to which definite names are given, and which are resorted to for various conditions which it will be my duty to describe this afternoon.

If we now turn our attention to the conditions under which these operations may be called for, the first one described is that which is of most doubtful necessity and is least often

required. Nephrorraphy may very rarely be justified in cases where the kidney is not fixed by the usual structures, and on this account gives rise to distressing symptoms. There are two conditions under which this organ may be liable to shift its position, and thus to give rise to symptoms which require that it should be fixed artificially to a definite location; either it may be movable behind the peritoneum lying free between it and the abdominal wall, or it may be floating within the cavity of the serous membrane and attached by a mesonephron to the spine, the latter condition being the rarer of the two. Both conditions are met with most frequently in females, particularly in those who have had frequent pregnancies, and it is much more frequent on the right than on the opposite side. The symptoms are those of occasional pain, varying in amount, aggravated by pressure, and often intensified at the period of menstruation, these symptoms being associated with the presence of a palpable movable tumour on one side of the abdomen. Sometimes the urine will contain blood, and the amount will be increased by manipulation, and in other cases the amount of urine will diminish as the size of the swelling may increase, owing to a temporary condition of hydronephrosis. Another cause of this condition is the emaciation which may result from any cause, and thus produce absorption of the fat which surrounds the organ and helps to maintain it in position. In the majority of cases the symptoms can be remedied by attention to the condition of the bowels, by abstention from violent exercise, and by the use of a belt, which in severe cases may be supplemented by an air-pad to support the organ in position. For an exaggerated condition of the above symptoms the kidney has been

several times removed, but the mortality has been so serious that a less formidable operation, such as that offered by nephrorraphy, should certainly in the first instance be given a trial, as the results thus obtained have been exceedingly satisfactory, especially when the organ on the opposite side can be ascertained to be healthy.

The condition termed hydronephrosis is brought about by many causes. It consists of an accumulation in the pelvis of the kidney and upper part of the ureter of a non-inflammatory fluid—that is to say, of urine in a modified condition, but not containing pus. It may occur congenitally—that is to say, it may result from some abnormal condition of the ureters, either by the existence of a twist or a valve in their continuity, or by some obstruction at their entrance into the bladder; and it is often found to co-exist to greater or less extent with the deformity of extroversion of the bladder; if bilateral it is necessarily incompatible with prolonged life, and therefore does not call for surgical interference. Again, it results not infrequently in children as the result of some accident by which the ureter is either temporarily blocked by clot or rupture, but in adults the causes may be summarized as any that lead to the temporary or permanent obstruction to the passage of urine from the kidney, and these include simple or malignant tumors, abscesses, bands or adhesions, the results of former inflammation causing pressure, obstruction to the urine by stricture, enlarged prostate, etc., displacements of the kidney or twisting of the ureter, the impaction of a calculus, or tumors of the bladder. The symptoms felt by the patients in this condition, which is often the result of disease in parts external to the urinary apparatus, vary much with the cause, and vary also greatly according to the amount and character and situation of the obstruction. If it is complete, a swelling caused by the urine accumulating in the parts which retain it increases

rapidly, and gives rise to a large and fluctuating tumor in the lumbar region of the side affected; as a result of this, pressure is put upon the secreting structure of the kidney, which checks its functional activity, and in the course of time may cause its obliteration, so that the capsule of the organ forms the boundary of the fluid; but if the obstruction be overcome, a large quantity of urine may pass suddenly into the bladder, and the tumor will for the time disappear, and under such circumstances the absorption of the gland structure is of much less rapid progress. If the fluid from such swelling be drawn off by an aspirator inserted behind at a point midway between the last rib and the crest of the ilium, and two and a half inches from the spinous process, it is not necessary for diagnostic purposes that this should consist of fluid presenting the ordinary characteristics of urine. On the contrary, it may contain but little urea and very large proportions of albumin, and this even in cases where the obstruction is recent or even transitory.

The diagnosis of tumor is often extremely difficult, and cannot be in many cases determined until an exploratory incision has been made; the difficulty is the greater in that, so far as I have seen, these tumors, although growing rapidly and attaining enormous size, may exist for a long time without causing great distress or emaciation, and this, added to the fact that often little or no indication is afforded by examination of the urine; indeed, it is not until the growth has invaded the pelvis or ureter that bleeding takes place, and it is then often very severe and is independent of exercise as opposed to the case of calculus, and is not accompanied by severe pain. Very rare, then, must the cases be in which removal of a kidney tumor can be successful in every way. Firstly, there is the fact that a large proportion of these neoplasms are malignant; secondly, there is the difficulty in dis-

tinguishing between them and the fluid collections which we have considered; and thirdly, there is the fact that such growths have usually attained a large size before they are detected, and connections have therefore become established with neighboring parts, and internal organs are infiltrated with secondary deposits. Still, with all these objections, there need be no hesitation as to the propriety of making early an incision by which the nature of the growth can be investigated, and if practicable its removal may subsequently be effected.

Now, having thus briefly reviewed the surgical diseases of the kidney, and the operations by means of which diagnosis may be confirmed or causes removed, let me recall to you some of the cases which have been under my hands, and which will illustrate what I have been saying.

A short time ago a woman of thirty-three years came to Dr. Bruce suffering from all those symptoms which are referable to a movable kidney. She was a Jewess and highly neurotic, and had had several pregnancies. The abdominal walls were flabby, and the right kidney could easily be felt, and could be moved upwards and downwards through a considerable arc. Examination increased the pain, which was at times said to be excessive. There were no urinary symptoms. She had worn various belts without benefit. After due consultation I performed the operation of nephrorraphy, using kangaroo tendons to secure the organ to the fascia of the loin, and passing them through the substance of the cortical portion of the gland. There was some haematuria for a day or two, but this soon passed off, and the wound healed quickly. On getting up she resumed the belt, and for a long time expressed herself as much benefitted. About a year later she came to report that the pains had recurred; but I could not on examination find any cause for

them, and the kidney appeared to be stationary.

The next case to which I would call attention is a woman at present in the Golding Ward. She was sent in from a dispensary by Mr. Collum, on account of the state of her urine, and on account of having recently passed three separate pieces of calculus. Two of these you can see. They appear to have been broken off another portion, and give the idea that they are casts of the calyces, and have been formed in the kidney. The patient is a delicate-looking woman of thirty-two years, and in early childhood suffered from hip-joint disease. On the inner side of the right thigh is the cicatrix of an abscess, and the hip-joint is completely ankylosed at almost a right angle to the pelvis. The left hip has also been diseased, and though there are no scars of abscesses, the joint is only capable of a very moderate degree of movement. The lordosis is extreme, and in consequence any examination of the loin is exceedingly difficult. Nevertheless she is married, and has had one child about a year ago. About February last she was a patient in Middlesex Hospital, under the care of Mr. Kellock, who performed nephrotomy upon the right kidney, and found it a mere sac with little of the secreting structure remaining. When she was admitted here, after passing three portions of calculus, she looked very ill, and was suffering great pain in the region of the left kidney. Mr. Kellock kindly came to see her with me, and told us the condition in which he had found the gland on the right side. The urine was acid, but contained a very large proportion of pus. No stone was found in the bladder, and the cystoscope showed nothing but a very inflamed mucous membrane, though, owing to the ankylosis of the thighs and the condition of the urine, this form of examination was not so satisfactory as could have been wished.



### HYPERTROPHY OF THE THYMUS.

König describes a case before the Berlin Surgical Society of a child which was brought to his clinic suffering from severe dyspnea and requiring immediate tracheotomy. The mother said that eight days after the child's birth it suffered from an attack of dyspnea, since which time the attacks recurred with increasing frequency and intensity. A small cystic tumor at the base of the tongue was observed; it was considered a possible cause of the dyspnea and was punctured, without giving the child any relief.

König felt a tumor over the sternum upon deep respiration and concluded to operate. After dividing the fascia he came upon the thymus, which compressed the trachea for three or four centimeters. When the gland was lifted up the dyspnea was relieved. He removed a piece of the thymus three to four centimeters long and two centimeters wide. The respiration at first remained somewhat labored, but the severe dyspnea was relieved. Doubtless the case was one of asthma thymicum.

L. F.

—Deutsche Medizinal-Zeitung, No. 27, 1897.

### STIGMATA OF DEGENERATION IN EPILEPSY.

Dr. A. Ferree Witmer in an abstract of a paper read on this subject before the Philadelphia Pediatric Society, June 8, 1897, said there were various findings in patient at the Pennsylvania Epileptic Hospital and Colony Farm, classified under three headings, viz.: (a) Morphologic deviations from normal; (b) functional deviations from normal; (c) purely psychic stigmata.

Under heading (a) the stigmata particularly marked were asymmetries of

the skull and face, dental anomalies, inflammations of the skin, and marked pallor independent of any organic disease. Under heading (b) were noted retarded puberty, various anomalies of the menstrual function, gluttony, merycism. Under heading (c) tests were made to determine the higher mental activities, such as attention, memory, and association. Each patient was requested to write as many words as possible in one, two, and five-minute periods respectively; also to write from memory a spoken, written, and a simple sentence when read; and lastly to write the associations of some familiar word (city, hospital, etc.). The results indicated a deficiency of mental activity, when compared with groups of healthy children of equal age.

L. F.

—Archives of Pediatrics, Aug. 1, 1897.

### CYSTITIS FROM COLON BACILLI IN CHILDREN.

Hutinel has seen cystitis due to colon bacilli in little girls with first vulvo-vaginitis, then an accidentally produced intestinal infection, and finally the cystitis. The cystitis usually begins with irregular fever, and the local symptoms soon become marked; frequent painful micturition, often followed by a few drops of blood; the urine contains albumen, an abundant deposit of muco-pus, and microscopically epithelial and pus cells, and the bacillus coli communis in large numbers. While the prognosis is usually not grave relapses are quite frequent, and the bacilli often remain in the bladder a long time. Pyelonephritis has been reported by Guyon as a complication. The question would naturally suggest itself whether this cystitis would not increase the dangers of erroneous diagnosis of blennorrhagia. Furthermore, the question might also

arise whether the reduced vitality of the bladder would not predispose to secondary mixed infections with other pathogenic bacteria present but hitherto latent, because of the comparatively sound condition of the bladder-wall.

L. F.

—*Revue Internationale de Medecine et de Chirurgie*, Vol. vii, 23.

## NEUROLOGY AND PSYCHIATRY.

BY HUGH T. PATRICK, M. D.

Spinal Cord in Leucemia.—Nonne, who has given much valuable information regarding the changes in the spinal cord induced by pernicious anemia and the symptoms resulting therefrom, now contributes two cases of cord disease from leucemia, a knowledge of which seem heretofore to have been confined to a single case reported by W. Müller (Inaugural Thesis, Berlin, 1895).

The first case was that of a 59-year-old man. The disease began six months before death with general debility, dizziness, and anorexia. Two months after the inception of the disease the liver and spleen were found to be greatly enlarged, the red blood-corpuscles numbered 1,896,000, the white 630,000, to the cubic millimeter, and the percentage of hemoglobin was only 40. Glandular enlargement was limited to a few glands in the groin and axillæ, some of which were as large as a filbert. Sensation, motion, and the reflexes were normal. While under observation the number of red blood-corpuscles increased slightly, and the spleen diminished in size, but the patient suffered from large intermuscular hemorrhages, and died of marasmus and catarrhal pneumonia. Microscopic examination of the cord revealed small myelitic foci or, more strictly speaking, foci of acute or subacute nerve degeneration, scattered through the white substance from the upper lumbar region to the medulla oblongata. Some of these degenerated points were large enough to be seen by the naked eye, and all stages of de-

generation were to be observed, from a simple puffed-up appearance of the myelin sheath and swelling of the axis cylinder, to segmentation, breaking up and disappearance of the nerve fibers, with compensatory hypertrophy of the neuroglia. Changes in the vessels, hemorrhages, cellular infiltration and extravasation of leucocytes were entirely wanting, and the gray matter throughout, together with the nerve roots, were absolutely normal.

The second patient, a 31-year-old man, noticed first some enlargement of the abdomen, and during the next two months marked general weakness developed. Irregular febrile movement then appeared, and the patient was admitted to the hospital, where he was found to have an enormous spleen, reaching to the right inguinal region. The lymphatic glands were not enlarged. Examination of the blood showed a great increase of white corpuscles—viz., 1,940,000 red and 910,000 white to the cubic millimeter. Objective symptoms of involvement of the nervous system were wanting. The patient died eight days after admission to the hospital and four months after the appearance of the first symptoms noticed. Careful microscopic examination of the spinal cord revealed lesions identical in character, size and distribution with those of the first case, the gray matter, nerve roots and vessels being intact. The Nissl method was not employed, as the material was hardened in Müller's fluid, and hence minute changes in the nerve cells were not to be positively excluded.

L. F.

—*Deutsche Zeits. fur Nerv.*, April 30, '97.

## MASTITIS.

One of the most distressing diseases with which we physicians are called upon to exercise skill, none will be so disastrous as either simple mastitis, or when a distinct suppuration has developed.

Edwin Rosenthal, M. D., of Philadelphia, in an extensive article on this subject, contributed to the Denver

Medical Times, gives his personal experience which is so valuable that we take pleasure in reproducing it. He says:

There is, perhaps, no complication of the "puerperium" that reflects so much on the attending physician as that which has its seat in the mammary gland. Indeed, the remembrance of the suffering of this period to the patient is so constant that it is one of the specific reasons given by many why they fear the pregnant state. For the physician an abscess of the breast is the worst thing that happens, and it is the chief cause that brings discussion between patient and doctor, and the most frequent cause for a change. It makes little difference to the patient what may be the cause of her trouble, she looks to the result, and she always feels, and sometimes not without good cause or reason, that the doctor is to blame, and if he be totally innocent, he invariably receives the full share of the blame. The different opinions held on the treatment of mastitis, as a preventative rather than as a cure, has prompted me to record my own experience, and if by this means I can cause discussion, my object will be accomplished. The chief point to be decided is: If mastitis threatens, what is to be done? First, in primiparae; second, in those cases of second, third and so on confinements, where mastitis is always the complication. It is mainly to answer the second question that I wish to confine this paper.

The question of the recurrence of an abscess of the breast depends upon the character of the first attack. As is well known, abscess of the mammary gland affect the parts in three different ways. First—The superficial variety, in which the tissues anterior to the gland proper suppurate. This is the simplest kind, and the use of the gland is not affected, nor is there at all any danger of its reappearance at a subsequent confinement. Convalescence from this permits the use of the gland, so that it would be wrong to consider it of sufficient importance to

prevent its use at a future confinement. It needs no further treatment, except the care which is generally bestowed at such periods. Second—The variety in which the gland itself is inflamed. Following inflammation comes suppuration, and the tissues composing the vital parts are affected and destroyed wholly or in part. In this variety, the substance of the gland being so affected, the gland ceases to be of further use, and at any subsequent confinement should receive the early and prompt treatment of the physician. The third variety is where inflammation and suppuration is deep-seated and posterior to the gland structure. Suppuration invades the tissues of the gland proper, and separates the gland from the pectoral muscles. In this variety the gland may be in part saved. It should also receive the early attention of the attendant, but effort can be made to save the gland, for the nipple and ducts may still be of use. Where, however, congestion takes place, and indications point to a threatened mastitis, it would be wrong to wait until suppuration, but treatment should be begun at once to prevent further flow of milk to the part, and the treatment should be the same as in the case of the second variety. This treatment is to the prompt method of preventing the gland from becoming inflamed, or, in fact, to prevent any milk from forming therein. The simplest method to accomplish this is by the use of adhesive strips, about two inches wide and two feet long. They are placed one upon another, extending from the sternum in front to the shoulder-blade behind for the lower ones; the upper ones extending across the breast to the dorsi muscles. Four to six strips are thus used, and their purpose is not only to compress the gland, but also to elevate the same. They are permitted to stay a week or ten days, unless loosened sooner, when they may be reapplied or fresh ones used. Care

is taken that the nipple is not compressed, the contents flowing out as the compression continues. This treatment is begun on the second day after childbirth, and always in the cases as described, for experience has taught me that the waiting or expectant plan of treatment was wrong, for after exposing the patient to the danger of a mastitis, and even to an attack itself, I was forced to put the baby to the bottle. I am therefore firmly persuaded that in such cases it is the proper way, and should be a fixed rule of practice to at once put the baby to the bottle first, then treat the breast by compression, second, and not make any attempt to begin a useless task, one that is not only fraught with danger and suffering, but one that is perfectly useless, as the results have invariably proven failures. This mode of treatment I pursue, whether one or both glands are affected, and I have reason to believe with a lessened mortality to the little ones than I would have had had I attempted to nourish it with a sick breast, a partial diet, or a diet obtained from an anaemic and suffering woman.

L. F.

### BACTERICIDAL PROPERTIES OF NASAL MUCUS.

Jonathan Wright after careful investigation, has arrived at the conclusion, that the prevalent idea among rhinologists, that the nasal mucus is bactericidal, is incorrect. In a number of experiments, it was found to have no effect upon the Klebs Loeffler bacillus, the streptococcus and the staphylococcus. On the other hand, the mucus did not contain as many germs as was supposed. L. F.

—Laryngoscope, June.

### NOTES.

Another serum cure for consumption hails from the continent. Professor Denys, of the University of Louvain, is reported to have discovered a serum which effectually cures pulmonary tuberculosis. Conclusive experiments are said to have been made, and Professor Denys will shortly communicate his wonderful discovery to the Academy of Medicine. The probability is that the "cure" will be found to be another Koch bubble.

—Med. Times and Hospital Gazette.

## BOOK REVIEW

A REVIEW OF RECENT LEGAL DECISIONS AFFECTING PHYSICIANS, DENTISTS, DRUGGISTS AND THE PUBLIC HEALTH, TOGETHER WITH A BRIEF FOR THE PROSECUTION OF UNLICENSED PRACTITIONERS OF MEDICINE, DENTISTRY OR PHARMACY, WITH A PAPER UPON MAN-SLAUGHTER, CHRISTIAN SCIENCE AND THE LAW, AND OTHER MATTER BY W. A. PURRINGTON, ESQ., OF

THE NEW YORK BAR.—PUBLISHED BY E. B. TREAT & CO., 241 WEST TWENTY-THIRD ST., NEW YORK; PRICE FIFTY CENTS.

The scope of this little brochure is pretty well covered in its title, and in it here are some vital points for the general practitioner and other relative to their legal liabilities. Citations of cases and legal opinions held on specific cases are important features. The book contains over 100 pages, bound in board, and set in Treat's own admirable style.


**THERAPEUTICS**  
 In charge of H. B. SHEFFIELD, M. D., New York.

**THERAPEUTIC HINTS.**

Try large doses of salol in protracted cases of gonorrhreal rheumatism.

Chronic urticaria frequently yields to the administration of tincture of strophanthus in five drop doses.

Ringworm of the body is quickly cured by one or two superficial applications of glacial acetic acid.

A full dose of Dover's powder will frequently avert an attack of bronchitis.

H. B. S.

**ATROPINE IN DELIRIUM TREMENS.**

Dr. Tunoin treated ten cases of delirium tremens with hypodermic injections of atropine hydrochlorate, in doses of 1-60 gr. After a single injection the agitation of the patient disappeared in from about fifteen to twenty minutes followed by deep sleep.

H. B. S.

*Gar. hebdom. de Med. March 12, 1899.*

**THE TREATMENT OF LEUCORRHEA BY MEANS OF YEAST.**

Dr. Theodore Landan, of Berlin, treated forty cases of gonorrhreal leucorrhœa by means of yeast with the following results:

1. In more than half the cases the treatment caused the disappearance of all microscopic evidence of the flow. This cure was permanent.

2. In a number of cases the primary result was as detailed above, but after prolonged omission of the treatment relapses occurred. But these cases were under ambulatory treatment, and

the possibility of a reinfection is not to be disregarded.

3. Some patients were thought unaffected by the treatment, though they themselves considered their condition as improved.

The yeast employed was the ordinary brewer's yeast kept on ice and renewed every three days. It is diluted till of a consistency permitting its injection by means of the ordinary gonorrhœal syringe, 10-20 c. c. being thrown into the vagina previously distended by a speculum. A tempor is introduced and left for twenty-four hours; all irrigation is suspended. This procedure is repeated every two or three days, the treatment requiring one or more weeks.

H. B. S.

*Merck's Archiv., vol. 1, No. 5, May, '99.*

**CARBOLIC ACID TREATMENT OF TETANUS.**

Dr. H. C. Wood treats tetanus by administering subcutaneously a 2 per cent. solution of carbolic acid, given at 2 or 3 hours intervals. The initial dose is about three grains a day and rapidly increased to 6 or 8 grains a day. He concludes that:

1. Carbolic acid gives better results in tetanus than does the anti-toxin treatment.

2. It acts by antagonizing the toxin and by quietening the nervous system.

3. It should always be given hypodermically, and in large enough doses, cases of tetanus being remarkably tolerant towards it.

4. Other methods of treatment should be continued, of which the discoverer lays especial stress upon the local disinfection of the wound.

H. B. S.

*Merck's Arch., Vol. 1, No. 5, May, '99.*

COUGH IN LARYNGEAL  
TUBERCULOSIS.

Codein Sulph. .... 3 gr.  
Sodium brom. .... 12 dr.  
Syr. Pruni Virginian. .... 4 dr.  
Aqnae q. s. ad. .... 2 oz.  
Sig.—One teaspoonful every four hours.

—Therap. Gaz.  
H. B. S.

## THE USE OF ELECTRICITY.

In a case of ordinary peripheral facial paralysis electrically examined on the tenth day, three types may be met.

1. Paralysis plus normal faradic irritability of the paralyzed muscles. Recovery will take place in from 2 to 3 weeks.

2. Paralysis plus diminished faradic irritability. Recovery takes place in from 6 to 8 weeks.

3. Paralysis plus loss of faradic irritability plus the R. D. Recovery takes from 3 to 9 months. If at the end of three months the faradic reaction has not returned, a guarded prognosis as regards time or ultimate complete recovery is to be given.

In the treatment of this affection electricity is, according to Dr. W. A. Turner, used (1) to maintain the nutrition of paralyzed muscles while the nerve is undergoing repair; (2) to relieve pain and spasm; (3) to promote the general nutrition of the body, more especially the muscular system.

In paralysis that form of electricity should be used to which the muscles respond. In types 1 and 2 faradism should be employed; in type 3 galvanism. But there is a useful method, the writer says, known as the combined galvanic faradic method. By means of a simple arrangement, the de Watteville table, both faradism and galvanism may be applied at the same time. In type 2 this would probably be the most satisfactory form. Electricity in muscular paralysis should be applied once a day, preferably combined with massage. In a case of

alcoholic paralysis affecting the legs, for instance, electricity may be given in the morning, massage in the evening. It is well to continue the electricity until the muscles present a reaction equal or almost equal to that of health.

In severe cases of trigeminal, intercostal and brachial neuralgia, and in other forms of pain, electricity is of great service. Galvanism is the form to be used, the anode being applied over the painful area, the other electrode at the back of the neck. If the pain is severe the patient should be provided with a battery, and allowed to apply electricity when the pain comes on.

Faradism should be avoided in spasm, such as facial or histrionic, and in rigidity and spasticity such as in hemiplegia, lateral sclerosis, and after myritis. It only increases the rigidity. Use galvanism for it tends to reduce spasm.

The third use of electricity is to increase the general nutrition of the neuro-muscular systems. For this purpose it should be combined with massage.

H. B. S.

Philad'a Med. Jour., May 13, 1899.

DANGER OF THE TRENDEL-  
ENBURG POSTURE.

The tendency of the day is to adopt the Trendelenburg posture in all operations upon the pelvis and abdomen. But the surgeon should not do this unless there is urgent need for the position. First, because it greatly increases the danger from the anesthetic, and prevents one of the principal methods of resuscitation from deep chloroform narcosis, viz.: lowering the head. Second, because there is considerable danger of secondary haemorrhage. The elevation of the hips forces the blood from the pelvis, and oozing from torn vessels does not occur until after the patient is in the horizontal posture—perhaps after closure of the incision. A number of such accidents have lately been reported.

—Canada Medical Record, Jan. 1899.


 PUBLISHER'S MISCELLANY.

## PROTARGOL IN THE TREATMENT OF OPHTHALMIA.

Pisenti has tried the above preparation of silver for the last six months in various types of ophthalmia and inflammations of the lachrymal canal. His results are decidedly encouraging. Protargol even in 10 per cent. solution (the strongest used by the author) does not cause so much and such lasting pain as a 2 per cent. solution of silver nitrate. In ophthalmia neonatorum the author used a 10 per cent. solution two or three times a day with excellent results. For catarrhal ophthalmia, a weaker solution (2 to 5 per cent.) was used. No very encouraging result was observed in granular conjunctivitis. Protargol does not cause any of those changes in the corneal epithelium which may sometimes be seen after the use of silver nitrate, and it has a power of penetration into the tissues five times greater than that of the nitrate; it is also an active germicide as far as the gonococcus is concerned.

Annal della Foculta di Med. di Perugia,  
vol. x, f. 1.

## BUREAU OF THE MEDICAL PRESS.

It has long been a subject of comment that the medical journals were slow to appreciate the advantages and benefits to be derived from a representation at the National and State Medical Society meetings, and, indeed, exhibiting an indifference in reporting the proceedings. The fact that a half-dozen journals are rarely seen at the meetings of the American Medical Association, surely reflects little credit upon the enterprise of our medical publishers. It seems, however, to have an explanation in the matter of expense. Unless the publisher or editor has the leisure time to attend the meeting himself, it is difficult to secure a representative who

will do justice to the publication, to say nothing of the expense of sending him and maintaining quarters during the session. Still there is no question that the society meeting affords the very best opportunity for a journal to get in touch with both the profession and the advertiser, and this plan, if systematically followed, will ultimately insure a degree of success unattainable in any other way. We are, therefore, pleased to announce that the Bureau service inaugurated by Mr. Chas. Wood Fassett several years ago, will be continued at the American Medical Association meeting in Columbus, June 6 to 9. A catalogue edition of the American Medical Journalist will be issued, containing a descriptive index to the medical periodicals and reference books contained in the Bureau, and advertising matter of various kinds will be distributed for members.

## NOT NECESSARILY OF "CONSULTATION" RANK.

The claim that from the moment more than one physician is called in and attends regularly upon a case every visit made by every physician employed takes rank as a "consultation," the Supreme Court of Louisiana declares, in the case of the Succession of Haley, as it is termed, can not be listened to. And the Court further holds that in fixing the value of the fees due by a succession (or estate) for professional services of physicians, the Court is justified in taking into consideration the value of the succession (or estate).

## PREVENTION OF HAY FEVER.

In the January 21st, 1899, number of The Journal of the American Medical Association, Dr. Alexander Rixa, of New York, contributed a very in-

teresting article on "Prevention of Hay Fever." After a highly interesting historical review, and a brief survey of the results achieved in the past few years, the writer resumes the results of his own investigations.

His ingenious researches for a number of years, regarding the etiology of hay fever, lead him to admit that the pollen of the Roman wormwood, ragweed (*ambrosia artemisiæfolia*) is the primitive and active cause of this peculiar disease. By inhaling these pollen he produced the symptoms of genuine hay fever. He writes as follows:

From the time I found the pollen to be the exciting cause of the disease, I concluded in a logical way upon the idea of rendering the receptacle aseptic by preparing the soil for the reception of the pollen. Naturally, they will find no proper soil for a possible generation, propagation or development, destroying their existence in embryo, so to speak, and with it the real cause of hay fever. For this purpose I decided on the following treatment.

About two weeks before the onset of the disease I commence to irrigate or sterilize the nasal cavity and the post-nasal spaces with a harmless anti-septic solution, using the douche and atomizer. After giving a great number of antiseptics a fair trial, I decided on hydrozone as the most innocuous and most powerful germicide. Hydrozone is a 30-volume aqueous solution of peroxide of hydrogen. At the beginning I use it for irrigation diluted in the proportion of one ounce of hydrozone to twelve ounces of sterilized water. Nearing the period of the expected onset of the disease, I increase the dose to two or three ounces of hydrozone to twelve ounces of the sterilized water, according to the severity of the disease, using the douche, either tepid or cold, four times a day—morning, noon, evenings and at bedtime—while during the intervals I use the atomizer, with a solution of hydrozone and pure glycerine, or

sterilized water, one to three, thus keeping the nares perfectly aseptic during the entire period, and preventing the outbreak of the disease in consequence thereof.

In most obstinate cases, when there is still some irritation in the nasal cavity, I give as an adjuvant the following prescription:

Acid boracic ..... 20 gr.  
Menthol ..... 4 gr.  
Glyco-thymoline ..... 2 oz.  
Sol. eucain B. 4 per cent., q. s. 2 oz.

Sig.—Use in atomizer.

As a rule this treatment was sufficient to avert the disease and keep the patient in perfect comfort.

#### THE AMERICAN-THERAPEUTIC ASSOCIATION.

The ninth annual meeting of the American Electro-Therapeutic Association will be held in Washington, D. C., on September 19th, 20th and 21st, 1899, under the presidency of Dr. F. B. Bishop, of Washington.

Quite a number of papers of great scientific value have been promised, and the Committee on Arrangements insures the members a very entertaining and pleasurable meeting. Aside from the session of the Association, the committee has completed arrangements for a trip to Mt. Vernon, one to Arlington, and several other social features.

The headquarters of the Association will be at Willard's Hotel, where special rates will be given to members and their families during the meeting.

FOR the past ten years I have constantly prescribed Peacock's Bromides, and find it the sedative and anodyne par excellence in all convulsive and neurotic lesions, and I prescribe no other. I find it superior to the commercial bromides in simple combinations. It will give me much pleasure to further utilize it as occasions demand.

CHAS. KELLY GARDNER, M. D.  
Huntington, W. Va.

ANTIKAMNIA. BY J. R. CLAUSEN,  
A. M., M. D.

It is with something like hesitation that we voice this endorsement of Antikamnia. Not because we are not prepared to give to it our most unqualified endorsement, but because so many eminent authorities have already done so and its worth is so generally recognized by the medical profession that what we may say in praise of this matchless remedy seems to us, as we believe it will be to others, wholly unnecessary.

After using it extensively in our own practice we have found it to be all that its name implies, an antidote for pain, and a never failing one at that. Inquiry among other physicians is but to have a repetition of our own experiences. Coupled with the experiences "it is always to be relied upon." The field of its usefulness is almost as boundless as is the confidence of the physician who has long prescribed or the patient who has often been relieved by its use.

In our own practice we have used it with equal success in all forms of headache and neuralgic affections. In relieving both the sharp shooting pains and the dull, persistant ache that are such distressing features of acute influenza we have found nothing to compare with it, and the excellent results obtained as a pain reliever in rheumatic diseases alone calls for loudest praise. But in no form of disease have we been more convinced of the value of Antikamnia than in the treatment of dysmenorrhœa. In every case in which we have used it the results have been the same, instant relief from pain. In one case the patient informed me that she had never been free from pain at the periods from her girlhood, and generally compelled to take to her bed for a day at least, but since taking Antikamnia she has been perfectly free from pain.

In conclusion we will quote Robert B. McCall, M. D., of the Medical College, of Ohio, on Antikamnia as exactly fitting our conclusions: "If there is any one drug that can be made to answer every need of the physician, for the correction of the multitudinous disturbances of innervation that occur in the various diseases he is called upon to treat, that one is Antikamnia.

MASSACHUSETTS COLLEGE OF  
PHARMACY.

## DEPARTMENT OF ANALYTICAL CHEMISTRY.

BOSTON, Mass., January 28, 1899.

Malt-Diastase Company,  
1 Madison avenue, New York.

GENTLEMEN.—I have recently made tests upon some *Malt-extracts Plain* to determine the number of parts, by weight, of reducing sugars, that one part of the extract will produce from starch within a given time, thus showing their comparative diastasic activity.

I purchased the samples in the open market, and the following result may be of interest to you.

The figures represent the number of grammes of reducing sugars (calculated in terms of *Maltose*), that one gramme of the extract forms, when in contact for 30 minutes with an excess of arrowroot starch paste, and are the average of two determinations.

0.3608, . . .	A diastasic malt, plain.
4.4531, . . .	A diastasic malt, plain.
6.2314, . . .	MALTZYME, Plain.

Respectfully,  
J. W. BAIRD, S. M., Ph.C., M. D.  
Professor of Analytical and Organic  
Chemistry.

## A NON-DEPRESSING ANALGESIC.

Dr. W. Gray states that the experience which he has had with salophen leads him to believe that its greatest value and efficacy lie in its employment for relief of muscular, gastric, gastro-intestinal, joint and head pains associated with influenza. As to its antipyretic value he regards it as inferior to phenacetin, for the reason that its action is more delayed, and the effect passes off sooner. For affording relief for influenza headache, especially when associated with giddiness and noises in the ears, salophen in doses of 15 grains, three or four times a day, is particularly valuable. Dr. Gray states that he has never noticed any depression following upon its administration.

—Medical Press and Circular.

## CHRONIC NASAL CATARRH.

BY DR. HAGEDORN, SPECIALIST IN RHINOLOGY, HAMBURG.

Ordinary chronic rhinitis, the common chronic, hypertrophic catarrh of the nasal mucous membrane, can be successfully treated by every practitioner without specialist knowledge. The author considers its etiology, pathology, symptoms and sequellæ, more especially as regards the eye and ear; and also its diagnosis, prognosis, and treatment. This latter in the past has been either chiefly medical or chiefly surgical, in accordance with whether secretion from or swelling of the mucous membrane was the most prominent factor in the semiology.

We have happily long passed the time of the "furer galvano-causticus," experience having taught us that cauterization of the nasal mucosa is not the cure for all catarrhs which it was long regarded to be. The author only destroys tissues that cannot be reduced by massage of the mucosa, especially spines and projections, by burning. He has always succeeded in reducing diffuse swellings of the membrane by means of massage with the hard rubber catheter recommended by Pollitzer for the drum of the ear. Massage causes a primary swelling, followed in a few minutes by reduction in size, after the fifth sitting this reduction persists until the following day. Twenty sittings are required on an average.

The procedure is safe and pleasant, at the very least, in comparison with the use of the cautery.

In cases where the exceptionally abundant secretion is especially annoying to the patient the author insufflates very finely powdered xeroform into the nasal cavities, thus effecting a more rapid desiccation and reduction in size of the affected membrane. In children whose chronic catarrh is consequent upon adenoid vegetations, after radical removal of the growths under chloroform narcosis (compare "Die ärztliche Praxis," year X, No. 6, March 15th, 1897).

Xeroform insufflations are the sole procedures required in a very large number of cases. Only in older children, who have had chronic rhinitis for a number of years, a short course of massage treatment is needed in addition to the adenoid operation.

—From "Die ärztliche Praxis," Wurzburg, 1899, No. 7.

## AN OLD ESTABLISHED THEORY DISPUTED.

The following letter from Dr. John H. Baer, Chief Surgeon Philadelphia Eye, Ear, Nose and Throat Infirmary, disposes of the theory of cellular growth. He writes as follows :

"I wish to tell you what remarkable work Unguentine did for me in a case just dismissed. Eight weeks ago a young girl, daughter of one of our prominent men in this city, was playing with matches. Her dress caught fire and she was fearfully burned, the extent of the burn being from the ninth rib to the axilla and from the axilla to the elbow. I kept Unguentine on as a dressing, and the result was not a scar to show of the great area of burnt skin and flesh. It has created quite a talk among the physicians here as it overthrows our theory of cellular growth. These unusual results obtained by the ointment are contrary to our teaching that no integument can be destroyed by any means and re-formed without an eschar tissue."

## SYRUP OF FIGS.

Many saline laxatives and cathartic pills are contraindicated in the treatment of habitual constipation on account of their tendency to deplete the system too rapidly. Physicians frequently report progressive inefficiency from their continued use. Doctors say that the more one takes of salts and pills the more constipated the system becomes, while on the other hand one enjoys both the method and results when Syrup of Figs is taken; it is pleasant and refreshing to the taste, and acts gently yet promptly on the kidneys, liver and bowels, cleanses the system effectually and overcomes habitual con-

stipation permanently. The great trouble with all other purgatives and aperients is not that they fail to act, when a single dose is taken, but that they act too violently. Ladies and children enjoy the pleasant taste and gentle action of Syrup of Figs, find it delightful and beneficial whenever a laxative remedy is needed. For business men it is invaluable, as it may be taken without inconvenience, and does not gripe nor nauseate.

#### UPBRAIDING THE DOCTOR.

Dr. Samuel Wolf, physician to the Philadelphia Hospital, and Neurologist to the Samaritan Hospital of Philadelphia, presents among others, a case which is of special value at this time. He says: "The entire experience of the writer with antikamnia is not confined to the series of cases on which this paper is based, although its previous use has been limited to a few prescriptions, and those in cases where it was given after the usual routine had been exhausted. It is, however, to a striking result in one of these instances, that the incentive to investigate more fully, is to be largely attributed. A man of 42, in the course of an attack of la grippe, was enduring extreme torture from the pain of a trigeminal neuralgia. The second ten grain dose of antikamnia gave such complete and permanent relief, that my patient, a druggist of large experience, upbraidingly asked me, "Why didn't you prescribe this remedy before?"

#### ALLOUEZ SPRING WATER.

"In Diabetes I consider Allouez Spring water indispensable. I have treated four cases of Diabetes Mellitus in the incipient stage, which yielded readily to the water, and several advanced cases which yielded only after

protracted use. My confidence is so strong that I do not now hesitate to treat sufferers with this dreaded disorder, as I feel certain that almost every case if not too far gone, can be cured or life prolonged for several years if treated with this water. It stops fermentation, assists assimilation and elimination, hence its uniform success as a remedy in the disorders of digestion."

—Chas. M. Koier, M. D., Chicago, Ill.

#### SEASONABLE PRESCRIPTIONS

##### DOUCHE FOR NASAL CATARRH, OZENA, ETC.

Antikamnia and Codeine Tablets, No. 24.

Dose:—Crush and dissolve six tablets in a pint of tepid water, and use one-third as a douche three times a day. Shake well before using.

##### SNUFF FOR ACUTÈ CORYZA, RHINITIS, ETC.

Acidi Borici Pulv.,.....1 dr.

Acidi Salicylici .....6 grs.

Antikamnia (genuine).....1 dr.

Bismuth Sub. Nit.....2 dr.

Use as snuff every one, two or three hours, as required.

THE Beecher family is one whose branches are very many and whose lines of work are as varied as the individuals. It is a grandniece of Henry Ward Beecher, Mrs. Charlotte Perkins Stetson, who is at present very much to the fore in relation to the economic emancipation of women. In the July number of *The Cosmopolitan* Mrs. Stetson will wage a pen warfare with Prof. Harry Thurston Peck over an article in the June number of *The Cosmopolitan*, "The Woman of To-day and To-morrow." Mrs. Stetson has something in the June number—a four-line poem on "Queer People." The illustrations by Oliver Herford are themselves queer.

